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Newsletter of the Alcohol and Drug Research Unit

The ***Report of the Working Group on Drugs Rehabilitation*** was launched by Noel Ahern, outgoing Minister of State for the National Drugs Strategy, on 7 June 2007.

The report outlines a comprehensive policy for drugs rehabilitation and represents 'the full integration of rehabilitation as the fifth pillar of the National Drugs Strategy'.

This report will be covered in the next issue of *Drugnet Ireland.*



# New Minister of State for drugs strategy

On 20 June the Taoiseach appointed Pat Carey, Fianna Fáil TD for Dublin North West, as Minister of State at the Department of Community, Rural and Gaeltacht Affairs with special responsibility for drugs strategy and community affairs. Mr Carey's portfolio, unlike that of his predecessor Noel Ahern TD, will not include responsibility for housing and urban renewal. Mr Carey has served as vice-chairman of the Joint Oireachtas Committee on Foreign Affairs and as a member of Oireachtas committees on European affairs and on EU legislation. He has also chaired the British–Irish Inter-Parliamentary Body.

# Draft Programme for Government

The draft programme for government agreed by the incoming coalition on 12 June addresses the issues of problem alcohol use and illicit drugs under the headings 'Health', 'Local & National Sports Facilities' and 'Justice'.

**Drugs:** Most of the actions relating to drug use are under the 'Justice' heading. The new Government will implement the recommendations of the working group on drugs rehabilitation, including providing extra detox beds and dedicated community employment places. Two cocaine-specific treatment centres will be established and approved pilot cocaine projects will be supported. The Government will support the development of projects by local and regional drugs task forces and targeted Garda anti-drug-use programmes in schools and third-level institutions, and will continue to use the Young People's Facilities and Services Fund to assist in the development of youth facilities and services in disadvantaged areas.

Actions aimed at reducing the supply of drugs include increasing Garda powers to allow random searches for drugs at particular places, times or events, expanding the Criminal Assets Bureau operational presence in each Garda division, and the mandatory registration of mobile phones. Measures to make prisons drug-free by prohibiting physical contact with prisoners and drug testing on arrival will be introduced. The Drug Court programme will be expanded and judges will have the option of sentencing certain offenders to mandatory drug treatment programmes in addition to prison terms.

Under the 'Local & National Sports Facilities' heading, the level of 'own funding' required from applicants to the Sports Capital Programme will be reduced in areas of urban disadvantage, such as RAPID or local drugs task force areas.

**Alcohol:** Under the 'Health' heading, the Government commits to implementing the recommendations of the working group on alcohol abuse. Actions relating to young people include raising awareness of the damage caused by binge drinking, supporting the establishment of alcohol-free youth cafés, and the doubling of penalties for all offences relating to providing alcohol to underage persons. Other actions include developing a code of practice for off-licences, using the tax system to promote low-alcohol and alcohol-free products, and providing early intervention programmes in all social, health and justice services.

Provision is made under the 'Justice' heading for an increase in penalties under the Public Order Act, especially for alcohol-related disorder. Under 'Sports Facilities', the Government will discuss the phasing out of sponsorship of sporting events by the alcohol industry.

*(Brian Galvin)*

The full text of the Draft Programme is on the Fianna Fáil website at www.fiannafail.ie.

contents



# New data on drug use in Ireland

On 22 March 2007 the National Advisory Committee on Drugs (NACD) in Ireland and the Drugs and Alcohol Information and Research Unit of the Department of Health, Social Services and Public Safety in Northern Ireland published the fifth and sixth bulletins of results from the 2002/2003 all-Ireland general population drug prevalence survey.[1] Bulletin 5 focuses on polydrug use in the adult population (15–64 years) and Bulletin 6 focuses on sedative, tranquilliser and anti-depressant use in the adult population.

For the purpose of Bulletin 5, polydrug use is defined as use of two or more drugs in the last month. Polydrug use involves the concurrent use of two or more of the following substances: alcohol, tobacco, any illegal drug or any other legal drugs (sedatives, tranquillisers or anti-depressants). The findings for Ireland are presented in this article.

Just under one-fifth (19%) of the 4,918 survey respondents reported that they had not used any substance in the last month. Among those who had used drugs in the last month, the most common substance combinations were:

1. 24% had used alcohol and tobacco
2. 1.9% had used alcohol, tobacco and at least one illegal drug
3. 1.4% had used alcohol and sedatives, tranquillisers or anti-depressants
4. 1% had used alcohol, tobacco and sedatives, tranquillisers or anti-depressants
5. 0.6% had used alcohol and at least one illegal drug
6. 0.5% had used tobacco and sedatives, tranquillisers or anti-depressants
7. 0.2% had used tobacco and at least one illegal drug
8. 0.2% had used alcohol, tobacco, at least one illegal drug, and sedatives, tranquillisers or anti-depressants
9. 0.1% had used tobacco, at least one illegal drug, and sedatives, tranquillisers or anti-depressants

The combination of alcohol, tobacco and any illegal drug was more commonly reported by men (2.7%) than by women (2.1%). A higher proportion of young adults (15–34 years) reported that they had used alcohol with tobacco than their older counterparts (35–64 years), 28% compared to 21%.

As expected, the results of the polydrug use survey reflect drug use in recreational situations rather than problematic drug use in socially deprived areas or among treated problem drug users.

For the purpose of Bulletin 6, sedatives, tranquillisers and anti-depressants were grouped as a collective and were not presented by their individual drug families. The main measures of use were lifetime (ever used), use in the last year (recent use) and use in the last month (current use).

**The key findings were:**

- One in five (22%) respondents reported that they had taken sedatives, tranquillisers or anti-depressants during their lifetime. Of these, 95% said that the drug was prescribed.
- Females reported higher prevalence rates than males for all three time measures.
- The average age for first use of sedatives, tranquillisers or anti-depressants was 28 years for males and 30 years for females. The average age of first use by those in the 15–34-year age group was 22 years, and by those in the 35–64-year age group 37 years; this may indicate two different patterns among the user population.
- Ten per cent of respondents had used sedatives, tranquillisers or anti-depressants in the last month and, of these, 84% had taken them on a daily basis.
- Sedative, tranquilliser or anti-depressant use was more likely among those who were aged over 35 years, or long-term unemployed, or had left school at primary level.

*(Jean Long and Siobhan Reynolds)*

1. National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (2007) *Drug use in Ireland and Northern Ireland. 2002/2003 drug prevalence survey: polydrug use results.* Bulletin 5; and *Drug use in Ireland and Northern Ireland. 2002/2003 drug prevalence survey: sedatives, tranquillisers or anti-depressants.* Bulletin 6. Dublin: National Advisory Committee on Drugs.

# Civil society joins international debate on drug controls

Between 12 and 16 March 2007 the Commission on Narcotic Drugs (CND), the central UN policy-making body dealing with drug-related matters, met for its 50th session in Vienna.[1] The session was attended by representatives of 47 states that are members of the Commission, observers for other UN member states and non-member states, representatives of organisations of the UN system, and observers for inter-governmental, non-governmental and other organisations. There were 81 registered civil society delegates and more NGO representatives included in government delegations.[2]

Prior to the meeting, both the United Nations Office for Drugs and Crime (UNODC),[3] mandated to assist member states in their fight against drugs, crime and terrorism, and the International Narcotics Control Board (INCB),[4] the independent and quasi-judicial monitoring body for the implementation of the UN international drug control conventions, published their annual reports, and these formed the basis for much of the debate over the five days. In his opening address, Antonio Maria Costa, executive director of UNODC, reaffirmed his assertion at the 49th session that global controls had stabilised the supply of illicit drugs, as well as the demand. He observed that specific problems, some very serious, still persisted, and that 'for even greater improvements we need stronger social vaccines to protect society against drugs'.

The agenda for the CND session included a thematic debate on the control of precursor chemicals, including those needed for the illicit manufacture of methamphetamine, amphetamine, 'ecstasy', heroin and cocaine. Drug demand reduction, illicit drug traffic and supply, and the implementation of the international drug control treaties were also discussed. Finally, there was a discussion on the progress made by governments in meeting the goals and targets set for the years 2003 and 2008 at the twentieth special session of the General Assembly (UNGASS), held in New York in 1998.

Looking forward to the CND session for 2008, member states agreed that UNODC will present an assessment report on achievements in respect of the 1998 UNGASS targets, and that the thematic debate will focus on 'underscoring the value of objective, scientific, balanced and transparent assessment'.[5] After the 2008 session, there will be a year for reflection, concluding with a major focus (and decisions) on the way forward at the 2009 CND session.

The 2008/9 period is also seen as an opportunity for the NGO community to reflect on its achievements in drug control, exchange ideas on approaches, reach agreements on ways to work together, and make recommendations to multilateral agencies and UN member states on future directions for drug control. To this end the Vienna NGO Committee on Narcotic Drugs (VNGOC),[6] working with the CND and UNODC, is hosting a 4th International NGO Forum to contribute to the 1998–2008 review and the forward-looking, agenda-setting exercise. The Forum will focus on three topics:

1. Highlighting tangible NGO achievements in the field of drug control, with particular emphasis on contributions to the 1998 UNGASS Action Plan such as achievement in policy, community engagement, prevention, treatment, rehabilitation and social-reintegration

2. Reviewing best practices related to collaboration mechanisms among NGOs, governments and UN agencies in various fields of endeavour and proposing new and/or improved ways of working with the UNODC and CND.

3. Adopting a series of high-order principles, drawn from the Conventions and their commentaries, that would be tabled with the UNODC and CND for their consideration and serve as a guide for future deliberations on drug policy matters.

In the run-up to the Forum, NGOs involved in drug control around the world are invited to complete a questionnaire as a means of collecting information towards the goals identified in the 1998 UNGASS Action Plan. A series of semi-structured interviews is also being conducted with key NGO informants to obtain more detailed insights on gaps and ideas for future direction. The Conventions, their commentaries and other relevant documents will be reviewed to identify a series of guiding principles for consideration and discussion by Forum participants. In addition, there will be a review of other NGO/UN consultation mechanisms with a view to recommending a new more systematic and substantive process for NGO contributions to CND and UNODC. Finally, a complete report will be prepared for tabling with CND, UNODC and other appropriate actors.

*(Brigid Pike)*

1. The official documents produced for the CND 50th Session are available on the CND page of the UNODC website at www.unodc.org
2. For an account of the CND 50th Session from an NGO perspective, see International Drug Policy Consortium (2007) *The 2007 Commission on Narcotic Drugs. IDPC Briefing Paper 5.* Available at www.idpc.info
3. UNODC (2007) *United Nations Office on Drugs and Crime Annual Report 2006.* Available at www.unodc.org
4. INCB (2007) *Report of the International Narcotics Control Board for 2006.* Available at www.incb.org
5. E/CN.7/2007/L.14/Rev.1, Measures to meet the goal of establishing by 2009 the progress achieved in implementing the declarations and measures adopted by the General Assembly at its twentieth special session. Vienna, 15 March 2007.
6. Established in 1983, the objective of the Vienna NGO Committee on Narcotic Drugs (VNGOC) is to support the work of the UNODC, provide information on NGO activities and involve a wide sector of civil society in raising awareness of global drug policies. Further information on the Forum, and the NGO questionnaire on UNGASS 2008 goals, may be found on the website of the VNGOC at www.vngoc.org

# First international conference on drug policy

Between 22 and 23 March 2007, 49 drug policy researchers from around the world met in Oslo for the inaugural meeting of the International Society for the Study of Drug Policy (ISSDP).[1] Conference participants heard some 30 papers, organised around the following themes.

### 1. Developing harm indexes for policy decisions

There is increasing interest in developing summary measures that express the severity of drug problems. For example, the UK Home Office has published an index for measuring outcomes of drug policy decisions.[2] Sandeep Chawla of the United Nations Organization on Drugs and Crime (UNODC) presented a paper on constructing policy-relevant harm indexes.[3] A number of other papers addressed various aspects of drug-related harm, including the specific nature of supply-side and demand-side harms and the evaluation of harm-reduction interventions.

### 2. Estimating government expenditures on drug policy

As governments spend an increasing amount of money on the effort to reduce drug use and related problems, there has been increased interest in developing effective ways of measuring the scale and composition of drug policy.[4] Speakers at the conference on budgets and costs included Luis Prieto of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

### 3. Modelling the effects of specific policies and programmes

There have been substantial advances in dynamic systems approaches, complex systems science and systems thinking in recent years. The application of these approaches to drug policy has the potential to allow close examination of the dynamic interactions between interventions, of the trajectories of drug use and harm, and of models within the policy-making process. A number of participants in the Australian Drug Policy Modelling Program (DPMP) presented papers on their work developing the evidence base for policy, developing, implementing and evaluating dynamic policy-relevant models of drug issues, and studying policy-making processes.[5]

### 4. Assessing the impact of harm reduction and substitution treatment initiatives

Harm-reduction practices are not necessarily directed only towards reducing drug-related harm to the individual; they are motivated also by public health and public safety concerns. The overall impact of harm reduction and substitution treatment on the epidemiological situation as well as on the drug market has less often been the object of research. Among contributors on this theme was Mary O'Shea of Merchants Quay Ireland, who presented a paper on the politics of safer injecting facilities in Ireland.[6]

### Drugs and public policy

In addition to the contributions on the four themes above, several papers addressed aspects of the policy-making process, including the philosophical underpinnings of drug policy, bridging the gap between researchers and policy makers, and the dynamics of drug policy and drug research.

The conference heard the first public report on the Drugs and Public Policy Project (DPPP). The DPPP was initiated in November 2004 as a collaborative effort by an international group of addiction scientists to improve the linkages between addiction science and drug policy. Seed funding was provided by the Society for the Study of Addiction (SSA). Current collaborators include Griffith Edwards, John Strang and David Foxcroft of the UK; Peter Reuter, Jonathan Caulkins and Keith Humphreys of the USA; Isidore Obot (Nigeria and WHO); Maria Elena Medina Mora (Mexico); Ingeborg Rossow (Norway); Jurgen Rehm (Canada); and Robin Room (Australia). It is intended to produce a book, modelled on *Alcohol: no ordinary commodity,*[7] which was sponsored by the World Health Organization and the SSA. The new book will include epidemiological data on the global dimensions of drug misuse, as well as a critical review of the scientific evidence relating to drug policy at the local, national and international levels.

### International Society for the Study of Drug Policy (ISSDP)

The ISSDP was formally constituted by the participants at the conference. A Board was elected, with Professor Peter Reuter, USA, as president, and Associate Professor Alison Ritter, Australia, as vice-president. It is planned to hold the second annual conference of the ISSDP in Lisbon in April 2008.

*(Brigid Pike)*

1. For further information on the ISSDP and the conference, visit www.issdp.org

2. MacDonald Z, Tinsley L, Collingwood J, Jamieson P and Pudney S (2005) *Measuring the harm from illegal drugs using the Drug Harm Index.* Home Office Online Report 24/05. Available at www.homeoffice.gov.uk/rds/pdfs05/rdsolr2405.pdf

3. In its 2005 World Drug Report, UNODC presented an index at the national level that attempted to capture differences in the sum of consumption, trafficking and production problems. The report is available at www.unodc.org/pdf/WDR_2005/volume_1_web.pdf

4. See, for example, papers from a symposium 'What drug policies cost', published in the journal *Addiction* (101) in 2006.

5. For further information on the Drug Policy Modelling Program, visit www.dpmp.unsw.edu.au

6. A version of this paper may be found at M O'Shea (2007) 'Introducing safer injecting facilities (SIFs) in the Republic of Ireland: "Chipping away" at policy change'. *Drugs: education, prevention and policy.* 14/1: 75–88.

7. Babor T, Caetano R, Casswell S, Edwards G, Giesbrecht N, Graham K *et al.* (2003) *Alcohol: no ordinary commodity. Research and public policy.* Oxford: Oxford University Press.

# President opens RADE's cultural showcase

President Mary McAleese with some of the participants in the RADE 2007 Showcase at the Project Arts Centre in Dublin (Photo: Bryan O'Brien, *Irish Times*)

RADE (recovery through art, drama and education) was established in August 2004 as an innovative programme for recovering drug users. Its purpose is to help participants 'find a path forward into personal development and education through participation in the arts'.[1] At present, there are 21 participants involved in the arts training programmes which are conducted in collaboration with some of Ireland's leading contemporary artists across all art forms.

President Mary McAleese opened RADE's 2007 Showcase in the Project Arts Centre in Temple Bar in April. The president was introduced by poet Theo Dorgan, who was MC for the evening. The event opened with poetry readings from Mick *(Elegy for Uncle Christy)* and Joanne *(Nobody knows what it's like)*. This was followed by a short documentary film, a Tai Chi display and a drama performance by the participants.

President McAleese set the activities and challenges faced by the participants in RADE in the context of the harms associated with problematic drug use: 'Civic society is generally impatient with addicts, frustrated at the waste of life, angry at the damage inflicted on the self and others. Families, friends and partners often reach exhaustion point too, so it is all the more important that there is an organisation like RADE that doesn't walk away defeated or overwhelmed by the enormity of the job.'[2] Directing her comments at the participants throughout her address, she commended them for their courage in taking on their addiction: 'It takes guts to take on the monster within that is addiction, and the works showcased here speak movingly of the courage and the commitment it has taken each artist to get here. When they took the first steps towards this day they were in an altogether different place – they were in many ways different people. Today they are stronger and wiser. They are men and women of achievement, people of substance not substance abusers.'

RADE has three primary objectives:

- to get Dublin City Council to develop RADE's current 'dilapidated' premises in New Street, Dublin 8, as a state-of-the-art centre, or to provide suitable alternative premises;
- to develop and expand its drama and film programmes;
- to increase the reach of its programmes into the community and to involve influential community forces, such as parents, more directly in its work.

*(Johnny Connolly)*

1. RADE (recovery through art and education) (2007) *Somewhere to flap your wings – Inside RADE 2006–2007.* Dublin: RADE.

2. The full text of President McAleese's remarks at the RADE Showcase is available in the Speeches section of the website www.president.ie

# HSE outlines plans for drug-related services in 2007

Approved in February 2007 by Mary Harney TD, Minister for Health and Children, the National Service Plan 2007 (NSP) of the Health Service Executive (HSE) outlines the HSE's plans in the drugs area during 2007.[1] It states that work will begin on scoping the transition of the management of alcohol services from mental health to social inclusion services, and that a review of how drug and alcohol services can have a better fit with the unitary structure of the HSE will be completed.

The HSE's drug-related services are provided primarily through Social Inclusion Services, which is part of the Primary, Community and Continuing Care (PCCC) directorate of the HSE. Table 1 (see p.6) summarises the HSE's Social Inclusion outputs in respect of drugs and HIV services for 2006 and the deliverables against which the HSE will be assessing its performance in 2007.

Table 2 (see p.7) outlines how the €6 million allocated in the government's 2007 budget to implement the HSE-related elements of the National Drugs Strategy will be spent.

The NSP also records that during 2007 the Population Health Directorate of the HSE will complete further iterations of the SLAN (Survey of Lifestyle, Attitudes and Nutrition) and ESPAD (European School Survey Project on Alcohol and Drugs), continue to work on health promotion campaigns in relation to, among other things, alcohol and tobacco, and continue to implement the Action Plan on Alcohol.

*(Brigid Pike)*

1. Health Service Executive (2007) *National Service Plan 2007.* Available at www.hse.ie

## HSE National Service Plan *(continued)*

**Table 1 Drugs and HIV services – outputs and deliverables for 2007 (after *HSE NSP 2007*: 38–39)**

| Focus | Output 2006 | Deliverable 2007 |
|---|---|---|
| Expand the Tier 3 teams. | Additional funding was provided for Specialist Adolescent Addiction Teams. | Continued provision of existing levels of service |
| Enhance treatment services with a particular focus on under-18s. | New protocols and a policy on treatment of under-18s were disseminated and promoted nationally. National Training Workshops were provided for frontline staff on the treatment of under-18s with serious drug problems.<br><br>Substance misusers to have immediate access to professional assessment, and treatment as deemed appropriate not later than one month after assessment. The extent of substance misuse in the under-18-year group needs monitoring.<br><br>**Indicator (AD3, AD4):**<br><br>■ Percentage of adults (new clients) commencing treatment within one month – 60% (heroin) 95% (all other substances).<br>■ Percentage of under-18s (new clients) commencing treatment within one month – 65% approx. | Increase the provision of training to staff on appropriate interventions for under-18s.<br><br>Implement the protocols and the new policy nationally in line with available resources.<br><br>Work towards improved performance in these areas. |
| Enhance treatment services to cocaine and polydrug users. | Information on the trends and prevalence of cocaine use was disseminated.<br><br>A workshop was provided on appropriate treatment interventions to address cocaine use. | Develop a model for the management of cocaine abuse and deliver appropriate training to HSE staff. |
| Combat substance misuse through a concerted focus on supply reduction, prevention, treatment and research. | | Develop a comprehensive action plan for the delivery of rehabilitation services in line with the National Drug Strategy review and the outcome of the Rehabilitation Working Group.<br><br>Monitor the prescribing of benzodiazepines. |
| Focus on reducing alcohol-related harm, including implementation of the recommendations of the Working Group on Alcohol and taking account of the recommendations of the Strategic Task Force on Alcohol. | Work on the Alcohol Aware pilot with the Irish College of General Practitioners (ICGP) commenced in 2006. | Implement relevant recommendations from the Strategic Task Force on Alcohol, within available resources.<br><br>Work with Emergency Department (ED) and Primary Care Services on the early detection and screening of people with problematic and dependent alcohol use.<br><br>Complete review of current mental-health-based alcohol services with a view to improved integration. |
| Number of clients in methadone treatment | Average of 6,800 per month | 6,800 (average per month) |
| Number of methadone treatment places used during the period | Average of 6,800 per month | 6,800 (average per month) |

## HSE National Service Plan *(continued)*

**Table 2 Investment funding in Social Inclusion services for 2007 to implement health-related aspects of the National Drugs Strategy (after *HSE NSP 2007*: 103–104)**

| Focus | Funding | Human resource implications estimated | Deliverable 07 |
|---|---|---|---|
| **Addressing health-related aspects of the National Drugs Strategy through:** | €6m (B) | | |
| Continued implementation of the report on treatment services for under-18s presenting with serious drug problems,<br><br>including the enhancement of consultant-led multidisciplinary teams | | 50 | Completion of teams in Dublin North East<br><br>Enhancement of teams in Dublin-Mid Leinster<br><br>Establishment of team in HSE South (Cork)<br><br>Establishment of team in HSE West (Limerick) |
| Expansion of harm reduction services, including needle exchange, to counter the incidence of HIV and hepatitis C among intravenous drug users | | | Continuation and expansion of programme that commenced in 2006. |
| Reorientation and expansion of treatment services and the upskilling of HSE staff to address changing patterns of polydrug use | | 4 | Cocaine and polydrug use programme established, national coordinator in place.<br><br>Two pilot sites identified and established. |
| Detox facilities programme | | 2 | Support for the establishment of residential detox programmes throughout the country. Initial places and sites identified in 2007. |
| A specific initiative for homeless persons | | 10 | Employment of eight counsellors to support addiction services targeted at homeless communities throughout the country. |

# Special Eurobarometer: Attitudes towards alcohol

Ireland tops the country scale for heavy drinking by a considerable margin.

In March 2007, a Eurobarometer special report, *Attitudes towards alcohol,*[1] was published. Commissioned by the Health and Consumer Protection Directorate-General of the European Commission, the main aim of this survey was to obtain a picture of European citizens' drinking habits and their attitudes towards measures that potentially influence alcohol-related harm. The study sample comprised over 28,000 participants from 29 European countries, including Ireland. Interviews were conducted face-to-face in people's homes and took place in October and November 2006.

The majority of Europeans drink, with 66% stating that they had consumed an alcoholic beverage in the preceding 30 days. The corresponding figure for Irish respondents was 70%, representing an increase of 10 percentage points since the Eurobarometer survey conducted in 2003. Irish people drink on fewer occasions than their European counterparts. Just 2% consume alcohol daily, compared to 13% of Europeans, while 41% stated that they drink once per week.

Although Irish people drink on fewer occasions, they reported a higher prevalence of heavy episodic drinking. The majority of the EU population reported having fewer than two drinks on a typical drinking occasion (70%), while just 10% usually consume five or more drinks in one sitting. Ireland tops the country scale for heavy drinking by a considerable margin, with just 28% consuming fewer than two drinks per drinking occasion and 34% usually consuming at least five drinks. Furthermore, when asked about the frequency of consuming five or more drinks on one occasion in the past year, 28% of Europeans stated they did so at least once a week, compared to 54% of Irish respondents, which was the highest recorded value. The survey also found men more likely to engage in binge drinking than women and, while younger people (aged 15–24) and students claim to drink on fewer occasions per month than the EU average, they are more inclined to binge drink than the average European.

Not a single respondent correctly identified the Irish BAC level as being in the range 0.60–1 g/l.

The survey also investigated opinions regarding the responsibility for and prevention of alcohol-related harm. At a European level, a slight majority (52%) consider individuals to be mainly responsible for protecting themselves from alcohol-related harm, although a significant proportion (44%) think that public authorities have to intervene in order to protect individuals.

Over two-thirds of the EU population (68%) believe that higher prices for alcohol would not discourage young people and heavy drinkers from consumption, and just 33% stated that they would buy less alcohol if prices were to increase by 25%. Fifteen per cent believe they would buy more alcohol if prices decreased by 25%. Younger respondents appear to be more sensitive to price changes, with 44% stating that they would buy less alcohol if prices increased and 26% claiming they would buy more alcohol if prices decreased.

There is broad support for putting warning labels on alcohol bottles in order to inform pregnant women and drivers of the dangers associated with drinking alcohol. Three-quarters of Europeans (77%) are in favour of such an initiative, while 82% of Irish people are supportive of warning labels. There is also strong support for measures that restrict young peoples' exposure to alcohol, with 76% approving of the banning of alcohol advertising that targets young people. All European countries are strongly in favour of prohibiting the selling and serving of alcohol to people under the age of 18. Eighty-seven per cent of Europeans and a similar proportion of Irish people (89%) favour such restrictions. Not surprisingly perhaps, a lower proportion of the youngest respondents (74%) favour controls that tighten regulations concerning themselves.

The survey also included questions pertaining to alcohol consumption and driving. It is recommended that the standard blood alcohol concentration (BAC) permitted for drivers should not exceed 0.5 g/l. All European countries, with the exception of Ireland, the UK and Malta (all three of which have a permitted BAC level of 0.8 g/l), have adopted this limit. Many respondents are not well-informed about the permitted BAC in their country, with Irish respondents extremely uninformed about the allowed BAC while driving. When given a choice of four answers, not a single respondent correctly identified the Irish BAC level as being in the range 0.60–1 g/l. This is surprising especially when one considers that this survey was conducted at a time when there was a lot of media attention in Ireland regarding the introduction of random breath testing. There is widespread support for reducing the permitted BAC for young and novice drivers to 0.2 g/l in all EU member states. Seventy-three per cent of all Europeans and 74% of Irish people favour this change. Eighty per cent of EU citizens believe that random police alcohol checks would reduce alcohol consumption prior to driving. Irish people demonstrated the second-highest level of support for this proposal (91%).

In conclusion, this survey shows an increase in the number of people drinking compared to 2003, but the frequency and the amount of consumption has somewhat decreased. However, this observation does not appear to apply to Ireland, which recorded the highest levels and frequency of binge drinking in the EU. There is also widespread support for measures aimed at protecting young people from premature exposure to alcohol and reducing alcohol-related road accidents.

*(Deirdre Mongan)*

1. TNS Opinion & Social (2007) *Attitudes towards alcohol.* Special Eurobarometer 272. Brussels: European Commission.

# Our love affair with alcohol

A public seminar, 'Alcohol: Is our love affair with alcohol causing more pleasure or pain?', was held by the Faculty of Public Health Medicine at the Royal College of Physicians of Ireland (RCPI) on 19 April 2007.

Dr Jim Kiely, chief medical officer with the Department of Health and Children, stated that the recommendations of the Strategic Task Force on Alcohol had not been introduced in spite of public support for changes in alcohol policy.

Marion Rackard, executive director of Alcohol Action Ireland, said there is not equal access to treatment services around the country for people with alcohol problems or their families. She said that alcohol was too easily available and too cheap, and there was too much tolerance for drunkenness. She highlighted the need for a National Alcohol Strategy and the political will to tackle the problem of alcohol misuse in Ireland.

Dr Declan Bedford of the Faculty of Public Health Medicine at RCPI spoke of the connection between suicide and alcohol consumption and said that 90% of suicides among under-30s were found to have alcohol in their blood and 58% had double the legal driving limit. In addition, 38% of road fatalities were alcohol related and every eighth new patient attending Accident and Emergency was there because of an alcohol-related injury. He also said that the recommendations of the task force needed to be implemented urgently and supported measures to increase alcohol taxation, decrease availability and reduce the exposure of children to advertising, sponsorship and promotions. However, he stressed that strong local and political leadership was necessary to achieve this.

*(Deirdre Mongan)*

# Alcohol consumption in an Irish university

In January 2007, the Geary Institute in University College Dublin (UCD) published preliminary results from its college study *Behavioural economics and drinking behaviour.*[1] The main aim of this study was to examine alcohol consumption in an Irish university, in particular the role of demographic factors, personality, age of drinking onset and peer drinking.

All the students in an Irish university were contacted via email and asked to participate in a web-based survey. In total, 4,500 students responded, representing approximately 20% of the student body. Information collected included personal details such as gender and age, physical health and psychological well-being, alcohol consumption patterns, personality, risk perception, time management and family background. Drinking behaviour was assessed by examining monthly alcohol expenditure and administering the AUDIT (alcohol use disorders identification test) screening examination. Single-equation regression models were used to study the determinants of alcohol consumption patterns and AUDIT scores.

The study found that whether a student drank or abstained was determined by a number of variables. When other factors were controlled for, it was found that females in general and students from families with a high parental income were more likely to drink. There was little evidence that parental drinking influenced students' decisions to consume alcohol. Drinking was related to closest-peer and outside-college-peer drinking, though not to college-friend drinking.

When the determinants of AUDIT scores were examined, the results revealed a substantial effect of peer-group drinking but very little effect of parental drinking. AUDIT scores were higher for those who began drinking at an earlier age. Both cannabis and ecstasy usage were associated with higher AUDIT scores, suggesting complementarities between alcohol consumption and illicit drug use. Males scored substantially higher than females on the AUDIT, even after controlling for other factors. Associated with lower AUDIT scores were high perception of risks related to drinking and conscientiousness in terms of personality.

The determinants of alcohol expenditure were also studied and it was found that alcohol expenditure and alcohol consumption were not strongly related. While disposable income had an effect on alcohol expenditure, it did not have an effect on the AUDIT score. This suggests that higher income students, rather than consuming more alcohol, tended to consume more expensive alcohol.

The authors concluded that income was a very weak explanatory factor for alcohol consumption, and that consumption was better explained by personality and peer factors than by parental resources, family background or disposable income. They also suggested that the interplay between parental, peer and sibling drinking and their effect on alcohol consumption should remain a high priority for future research.

*(Deirdre Mongan)*

**Consumption was better explained by personality and peer factors than by parental resources, family background or disposable income.**

1. Delaney L, Harmon C and Wall P (2007) *Behavioural economics and drinking behaviour: preliminary results from an Irish college study.* Dublin: UCD Geary Institute.

# Criminal Justice Act 2007

The Act contains proposals for mandatory sentencing for offences linked to organised crime, including firearms and drug trafficking offences.

The Criminal Justice Act 2007 was published by the Government on 15 March of this year, passed by the Oireachtas (Parliament) on 24 April, and signed into law by the President on 10 May.

The Act contains a number of important changes to the criminal justice system, including increased Garda detention powers, changes to existing provisions in relation to the right to silence and the introduction of mandatory sentencing for a range of offences. Many of these changes have been introduced in the context of growing concern about drug-related crime.

Currently, seven-day detention powers are available to the Garda Síochána (the Irish police) under the Criminal Justice (Drug Trafficking) Act 1996. Part 9 of the Criminal Justice Act 2007 extends the scope of these powers to, among other offences, murder involving the use of a firearm or explosive and murder of a Garda member or prison officer in the course of their duty.

The Act amends existing provisions relating to the right to silence by clarifying the circumstances in which inferences may be drawn from the refusal of an accused person to answer certain Garda questions. Such inferences can then be used as evidence against that person during court proceedings. Part 4 of the Act allows for inferences to be drawn when an individual fails or refuses to account for objects, substances or marks on their person and where the Garda member reasonably believes that such matters may be linked to the commission of an offence. However, the Act provides for certain safeguards for the accused. For example, the accused will not be convicted of an offence solely or mainly on such inferences and the section shall not apply unless the interview is recorded by electronic or similar means.

Part 3 of the Act contains proposals for mandatory sentencing for offences linked to organised crime, including firearms and drug trafficking offences. Under these proposals the court must impose a sentence that is at least three-quarters of the maximum sentence permissible under the law for that offence. If the maximum term is life imprisonment, the court shall specify a term of imprisonment of not less than 10 years.

Part 5 of the Act proposes amendments to the Misuse of Drugs Act 1977, specifically in relation to the area of sentencing of those in possession of drugs with intent to supply. The key provisions contained in this section of the Act include the following:

- The minimum period of imprisonment for those convicted under Section 15A or 15B of the Misuse of Drugs Act 1977[1] is to be 10 years, aside from some exceptional circumstances whereby the court determines that it would be unjust to impose such a sentence.[2]
- The minimum period of imprisonment for those convicted of a second or subsequent offence under Section 15A or 15B of the Misuse of Drugs Act 1977 is to be 10 years.

The main purpose of these provisions is to ensure that mandatory sentencing for supplying drugs should be imposed in all but the most exceptional circumstances.

The Irish Human Rights Commission (IHRC)[3] and the Irish Council for Civil Liberties (ICCL)[4] have expressed concerns about a number of provisions in the new Act. The IHRC refers to seven-day detention as 'a serious curtailment of a persons right to personal liberty…that warrants real cause and justification' (p. 3). This view is echoed by the ICCL, which questions the merit of extending such powers to a further range of offences when the current provisions under the Criminal Justice (Drug Trafficking) Act 1996 are, according to the ICCL, 'rarely, if ever used' (p. 6). Furthermore, the IHRC contends that the introduction of this measure may result in Ireland violating its obligations under the European Convention on Human Rights and the International Covenant on Civil and Political Rights.

Both the IHRC and ICCL have expressed concerns over the changes in sentencing practice introduced by the Act. The ICCL maintains that these new rules on mandatory sentencing may 'impinge upon the constitutional duty of judges to ensure that sentences are proportionate to both the gravity of the crime and the personal circumstances of the offender' (p. 8). This view is supported by the IHRC, which states that provisions which impose on the judiciary an obligation to sentence an offender to a specific term of imprisonment raise 'fundamental concerns' in relation to the separation of powers doctrine and judicial discretion in relation to sentencing (p. 4).

Both the ICCL and the IHRC, together with leading barristers[5] and the Law Society,[6] have expressed disquiet in relation to the timeframe in which the measures were enacted. The Law Society has called for greater debate about the provisions of the legislation.

*(Johnny Connolly and Angela Morgan)*

1. These sections relate specifically to possession of drugs with intent to supply.
2. For example, cases in which the convicted person pleaded guilty to the offence or provided assistance in the investigation of the offence. The Bill also states that if a person convicted of an offence under section 15A or 15B of the Misuse of Drugs Act was addicted to one or more controlled drugs at the time of the offence and if this was deemed to be a key factor in the commission of the offence, then the sentence can be reviewed after five years.
3. Irish Human Rights Commission (2007) *Observations on the Criminal Justice Bill 2007.* Dublin: Irish Human Rights Commission. www.ihrc.ie/press_releases
4. Irish Council for Civil Liberties (2007) *What's wrong with the Criminal Justice Bill 2007?* Dublin: Irish Council for Civil Liberties. www.iccl.ie
5. Letter to the *Irish Times* of 21 February 2007.
6. Law Society of Ireland (2007) 'Law Society's deep concern at Government's intention to rush through far-reaching changes in criminal law'. Press release 27 February 2007. Retrieved 04 May 2007 from www.lawsociety.ie/displayCDAContent.aspx?groupID=149&HeaderID=7024&code=latest_news

# Task force adopts new strategic approach

In March 2007 Minister Noel Ahern TD launched *Research leading to a future strategy for Dublin North East Drugs Task Force.*[1] The document reports that a growing range of drugs is being used in the task force area, that polydrug use has become increasingly common, and that, in contrast to heroin use, there is no apparent association between cocaine or cannabis use and socio-economic background.

The definition of prevention is to be widened to include individual, community and family 'risk' as well as 'protective' factors. Formal and informal prevention methods are to be used, and channels are to include schools, the media, outreach, and initiatives in respect of active citizenship and 'social capital'.

The provision of treatment and rehabilitation options will follow a polydrug use and continuum of care approach, and alternative project approaches will be offered, to cater not only for opiate users but also for polydrug and alcohol users, who may be less likely to seek assistance through existing projects. The task force will explore the establishment of a community-based project integrating medical and social treatment options. The quality of services will be improved through training and development for service deliverers, and the establishment of a users' forum.

Supply and control initiatives will include building a better relationship between police and the community; the development of a toxic substances protocol; setting up an information line for passing on information to the gardaí; and support for social planning in new and existing areas, to help reduce the incidence of drug dealing and anti-social behaviour.

Targeting of services is also highlighted. Prevention, diversionary and treatment services are to be developed specifically for young people. Families will be the subject of targeted interventions in the areas of prevention, harm reduction, treatment and ultimately rehabilitation and social reintegration. Special and focused initiatives for cocaine users are to be explored.

Stakeholders interviewed for the strategy were generally of the view that in recent years the task force has 'lost some direction, vibrancy and relevance to current drug problems' (p. 56). The report recommends a raft of structural changes to revitalise the task force, including focusing the role of the task force more narrowly on developing overall policy, developing a thematic annual work plan, overseeing the implementation of strategy and governance; strengthening the expert or advisory roles of the task force's sub-committees; setting up local area committees to develop local actions and measures linking in with new and existing local projects; building a community representative structure to ensure the community remains at the heart of the task force while also strengthening accountability; and establishing a technical support unit to assist the funded projects and services in accessing the latest research, information and best practice.

Finally, acknowledging that the solution to the drugs problem is bigger than the task force, the strategy identifies a series of initiatives to develop integrated/joined up/interagency responses, to investigate the relationship of drug problems to social exclusion and the local economy, and to undertake advocacy, lobbying and networking.

Not considered in *Research leading to a future strategy* are the efficiency, effectiveness, potential impact and value for money of the options identified in the report. These matters were the focus of an expenditure review of local drugs task forces completed in October 2006.[2] Among its findings and recommendations are several relevant to task forces reviewing their strategies. For example:

- Consideration of the likely impact and value for money of projects should inform the selection and overall mix of projects.
- To enhance efficiency, the review recommends the establishment of clear reporting relationships and related monitoring systems, the development of standard monitoring templates for projects, and the adoption of a system of performance indicators for projects, LDTF processes, individual LDTFs, and the LDTF Programme as a whole.
- While considering the LDTF model effective, the review raises a concern regarding the feasibility of the model: '…there is a widely held view that the energy and capability of the community to engage in drug interventions is subject to limits. This indicates that relatively realistic targets for the LDTF Programme should be set going forward' (p. 47).

*(Brigid Pike)*

1. Watters N (2007) *Research leading to a future strategy for Dublin North East Drugs Task Force.* Dublin: Dublin North East Drugs Task Force. Available online at www.dnedrugstaskforce.ie

2. Goodbody Economic Consultants (2006) *Expenditure review of the local drugs task forces.* Commissioned by the Department of Community, Rural and Gaeltacht Affairs. Available online at www.pobail.ie

# An overview of cocaine use in Ireland


The report reveals an increase in the number of cocaine-related offences from 180 in 2000 to 1,224 in 2005.

The number of treated cases reporting cocaine as a main problem drug increased by 262%, from 86 in 1998 to 311 in 2003.

The National Advisory Committee on Drugs (NACD) launched the report *An overview of cocaine use in Ireland: II* [1] on 8 March 2007. Prepared jointly by the NACD and the National Drugs Strategy Team (NDST), the report looks at the prevalence, prevention and treatment, and consequences of cocaine use in Ireland.

This report updates the baseline information presented in the NACD's 2003 cocaine report.[2] Dr Des Corrigan, chairman of the NACD, stated at the launch that all indicators show a continued increase in cocaine use that crosses all social strata.

Examining data from the NACD/DAIRU (Drug and Alcohol Information and Research Unit, Northern Ireland) Drug Prevalence Survey 2002/2003,[3] the authors conclude that cocaine use is highest among the 15–34 age group, is predominantly an urban phenomenon and is more common among males than females. The last point is consistent with findings from the College Lifestyle and Attitudinal National (CLAN) survey in 2005.[4]

Comparisons between data collected in the 1998 and the 2002 National Health and Lifestyle Surveys (SLAN)[5] indicate that cocaine use has increased. In 1998 1.8% of males and 0.6% of females surveyed had used cocaine in the last year. In the 2002 survey, levels of cocaine use in the last year had increased to 3% among males and 1.9% among females. Data from the Human Toxicology Section of the State Laboratory, which carries out analysis for coroners and criminal cases, and the Medical Bureau of Road Safety, based on road safety tests, indicate an increase in cocaine-positive tests between 2002 and 2005.

Using Garda data on offences under the Misuse of Drugs Act 1977, the report reveals an increase in the number of cocaine-related offences from 180 in 2000 to 1,224 in 2005. Forty-seven per cent of the cocaine-related offences recorded in 2005 were in the Dublin Metropolitan Region. The report shows that both Garda and Customs seizure data indicate a growing supply of cocaine in Ireland. In 2005 cocaine was the second most commonly seized drug after cannabis resin.

Data from the National Drug Treatment Reporting System (NDTRS) presented in the report are representative of people who attend for treatment for problem cocaine use, rather than of the general population using cocaine. Analysis of this data indicates a sustained increase between 1998 and 2003 in the number of treated cases reporting cocaine as a problem drug. The number of treated cases reporting cocaine as a main problem drug increased by 262%, from 86 in 1998 to 311 in 2003. The number of cases reporting cocaine as an additional problem drug increased by 394%, from 454 in 1998 to 2,244 in 2003. The majority (92%) of cases reporting cocaine as their main problem drug in 2003 used one or more additional drugs. Cannabis, alcohol and ecstasy were the most common additional drugs reported among these cases. Cocaine was reported as an additional drug in cases where opiates, cannabis or ecstasy were reported as the main problem drug. Data presented from the Hospital In-Patient Enquiry System (HIPE) also indicate an increase in the number of cases treated for cocaine-related problems in the years up to 2004. In relation to the method of administration reported by people attending treatment for cocaine use, 70% reported snorting, 17% reported injecting and 11% reported smoking cocaine.

According to the authors, evidence from the data collected in the Research Outcome Study in Ireland (ROSIE), for which the study sample consists of problem opiate users in treatment, suggests that current treatment services have contributed to reducing both opiate use and cocaine use. The authors report that, although no pharmacological substitution treatment is available for cocaine use, existing evidence indicates that many approaches currently being practised in treatment services, such as cognitive behavioural therapy, brief interventions, group therapy/counselling, contingency management, and peer leadership, work well with cocaine users. However, the authors state that current treatment services require a more cocaine-specific focus in order to encourage cocaine users to avail of such services.

At the launch of this report, Dr Corrigan highlighted the impact cocaine is having in the community, in terms of sharp increases in public disturbance, noise, intimidation and violence, while individuals are experiencing disrupted personal relationships, reduced productivity, loss of employment and income as well as physical and/or mental ill-health. Physical problems, including heart conditions, strokes, nasal damage and breathing problems, are associated with cocaine use. Intravenous cocaine use can lead to abscesses, blood clots and a range of systemic infections, including HIV and hepatitis B and C. Mental health problems include depression, agitation, anxiety, compulsive behaviour, aggression and paranoia. The authors report that levels of alcohol use among cocaine users are high. Alcohol and cocaine, when used together, combine to form a more toxic substance called cocaethylene.

The report makes 13 recommendations, focusing mainly on treatment but also covering supply, prevention and research. Those relating to treatment include:

- Establish stimulant-specific interventions in areas where cocaine problems are acute.

## Overview of cocaine use *(continued)*

- Re-orient drug treatment services from drug-specific interventions to treatment tailored towards the individual regardless of the drug(s) they use.
- Dispel the myth that there is no effective treatment for cocaine use.
- Launch needle-exchange and related harm-reduction strategies.
- Identify and meet training needs of frontline staff.
- Improve working relationships between GPs, A&E staff and the drug services.
- Include cocaine among the problem drugs addressed by prison drug treatment services and drug awareness programmes.

*(Ena Lynn)*


1. National Advisory Committee on Drugs and the National Drugs Strategy Team (2007) *An overview of cocaine use in Ireland: II.* Dublin: Stationery Office. www.nacd.ie
2. National Advisory Committee on Drugs (2003) *An overview of cocaine use in Ireland.* Dublin: Stationery Office. www.nacd.ie
3. National Advisory Committee on Drugs and Drug and Alcohol Information Research Unit (2006) *Drug use in Ireland and Northern Ireland. 2002/2003 drug prevalence survey: cocaine results.* Bulletin 4. Dublin: National Advisory Committee on Drugs.
4. Health Promotion Unit (2005) *The health of Irish students.* Dublin: Department of Health and Children.
5. Centre for Health Promotion Studies, NUI Galway (2003) *Survey of lifestyle, attitudes and nutrition (SLAN) and the Irish health behaviour in school-aged children (HBSC) survey.* Dublin: Department of Health and Children.


# Evaluation of projects to treat cocaine users

In 2004, the Department of Community, Rural and Gaeltacht Affairs requested the National Drugs Strategy Team (NDST) to identify projects that would tackle the growing problem of cocaine misuse in Ireland. In response, the NDST established the Cocaine Sub-Group to recommend pilot interventions aimed at different types of cocaine users.

The three pilot treatment interventions selected were:

- A community-based project involving St Dominic's Community Response Project and Killinarden's Community Addiction Response Programme, Tallaght, for problematic intranasal cocaine users.[1] The interventions planned were advertising service availability, project meetings, relationship building, individual care plans, individual counselling, and holistic therapies.
- Three inter-disciplinary, evidence-based interventions at Castle Street Clinic in the HSE South Western Area for polydrug users.[2] The planned interventions employed a combination of individual and group counselling and cognitive behavioural therapy approaches.
- A peer-support training project in the Women's Health Project, Baggot Street and in Chrysalis, Benburb Street, for women using cocaine and working in the sex industry.[3] It was envisaged that the project would train participants to provide accurate information on sexual health and drug use to their peers.

A fourth project, selected and implemented by Merchants Quay Ireland,[4] involved the provision of Tier 1 and Tier 2 training for health and social care staff working with cocaine users. The results of the training evaluation are not presented in this article.

Goodbody Economic Consultants were appointed as external evaluators for the pilot treatment projects. In addition, the management committee for the Women's Health Project decided to conduct an internal evaluation. The objectives of the external evaluation were to analyse what was achieved by the projects and report the lessons learned. In order to do this, the evaluators were to examine the structures, effectiveness, efficiency and value for money components of the projects.

The project based in **Tallaght** was implemented in line with its original design. It commenced in February 2005 and ended in April 2006. The project employed six staff members on a part-time basis. The service was provided through two evening sessions and one afternoon session. The cocaine treatment service was promoted through a media campaign and proactive outreach work. The project communicated with cocaine users and concerned persons by telephone and received an average of 20 calls per week. Ninety-nine cocaine users attended the project, of whom 60 (61%) returned more than once. The uptake of complementary treatments, such as acupuncture and Indian head massage, was high. A further 60 people were assisted by the outreach worker. Seven clients were interviewed at the end of the project, of whom four were abstinent from all drugs and two said that their suicidal thoughts had ceased. According to the evaluators, the project was effective and very good value for money.

At the implementation stage, the intervention for the project based in **Castle Street** was modified

## Evaluation of cocaine projects *(continued)*

to provide participants with a group counselling programme consisting of a 90-minute session each week for 12 weeks. The topics for the counselling sessions were: understanding addiction, process of recovery, managing cravings, healthy relationships, self-help groups, support systems, managing feelings and coping with guilt and shame. It was envisaged that three groups of 12 cocaine users would complete the programme. The project was implemented in 2005 and used existing staff resources. Two group counselling programmes were completed during the pilot period. Twenty-six polydrug users were referred to the project, of whom 14 were considered suitable to attend. Of the attendees, six completed the programme and five completed the post-intervention assessment. Of the five attendees assessed, one was abstinent from all drugs, two had reduced their cocaine and alcohol use, and two had reduced their cocaine use but not their alcohol use. The evaluators identified a number of weaknesses in the project design and implementation. The selection and referral process had serious flaws in that a high number of those referred were not suitable for the programme. The gap between counselling sessions was too long. Active drug users and those who were abstinent attended the same programme and this caused conflict. After-care was provided only to those who attended the second group and uptake was low. The programme design did not take account of the participants' other commitments (such as child care, training and employment) and this reduced attendance. There was no leadership or administrative support provided for the programme and the monetary resources allocated were not used. The evaluators recommended that this approach to cocaine treatment had merit but that the weaknesses identified must be addressed in any future programmes.

The project based in both **Baggot Street and Benburb Street** changed its original objective from one of encouraging peer support to that of identifying participants who would invite other women (peers) to information and/or complementary therapy sessions. The topics for the information sessions were: harm reduction, working in a safe environment, general and sexual health, hepatitis C, effects of cocaine use and effects of complementary therapy. The complementary therapies were acupuncture, Indian head massage, Reiki, stress balls and upper body massage. The project management committee employed an experienced outreach worker on a part-time basis and introduced a complex system of payments for those attending the project. The project commenced in October 2005. Twenty-two women were contacted through the project, of whom 18 (7 participants and 11 peers) attended at least one project activity. Attendance at complementary services was better than that at information sessions, which did not hold the interest of the women; according to the external evaluators, this may have been linked to rates of payment. During the course of the project, it was observed that many of the women had complex social and medical problems and the project activities were not broad enough to address such issues. The outreach worker did address some of these problems through referrals to and negotiations with other services. The external evaluators reported that they could not form a judgement as to whether this project was effective or not without knowing the results of the internal evaluation.

*(Jean Long)*


1. Goodbody Economic Consultants (2006) *Evaluation of the pilot cocaine project in Tallaght.* Dublin: Department of Community, Rural and Gaeltacht Affairs.
2. Goodbody Economic Consultants (2006) *Evaluation of the pilot cocaine project in Castle Street Clinic.* Dublin: Department of Community, Rural and Gaeltacht Affairs.
3. Goodbody Economic Consultants (2006) *Evaluation of the pilot cocaine Women's Health Project.* Dublin: Department of Community, Rural and Gaeltacht Affairs.
4. Crampton W (2005) *An evaluation of a cocaine training programme.* Dublin: Merchants Quay Ireland.


All four evaluation documents are available at http://www.pobail.ie/en/NationalDrugsStrategy/EvaluationsofthePilotCocaineProposals/

# Crack cocaine workshop

On 3 April 2007, URRÚS, a community addiction studies training centre in Ballymun, held a training workshop on crack cocaine. The workshop was facilitated by Greg Christodoulou and focused on a number of key areas:

- the history of crack cocaine
- the physical and psychological effects of the drug
- the outcomes of short- and long-term use
- effective intervention therapies.

A number of key points emerged from the workshop:

- Crack cocaine, first developed in the 1970s, is produced from cocaine powder mixed with substances such as ammonia or sodium bicarbonate and then heated. The resulting substance solidifies into a rock form enabling it to be smoked.
- Crack cocaine is purer than cocaine powder and provides an immediate and intense experience for the user.
- Crack is considered to be psychologically, rather than physically, addictive. The physical effects of frequent and long-term use of crack cocaine include respiratory problems, such as bronchitis, and an increased risk of heart attack and stroke. Psychological outcomes include paranoia, depression, anxiety and cocaine psychosis.
- There are a number of recognised treatments for crack cocaine addiction, including cognitive behavioural therapy and non-residential drug-free counselling.

*(Sinéad Foran)*

For further information on the various training courses and workshops available, URRÚS can be contacted at 01- 846 7980 or email urrus@iol.ie.

# ROSIE Findings 3: summary of abstinence treatment outcomes

The Research Outcome Study in Ireland (ROSIE) is being conducted by a team at the National University of Ireland, Maynooth, on behalf of the National Advisory Committee on Drugs (NACD). The aim of the study is to recruit and follow opiate users entering treatment and to document their progress after six months, one year and three years.

At baseline, the study recruited 404 opiate users aged 18 years or over entering treatment or, in the case of a sub-sample of 26 (6%), attending needle-exchange services. The participants were engaged in one of three different forms of treatment: methadone maintenance/reduction (53%, n=215), structured detoxification (20%, n=81) and abstinence-based treatment (20%, n=82).

The treatment outcomes presented in the first two papers in the ROSIE Findings series have been reported in previous issues of *Drugnet Ireland.* The third paper in the series, Findings 3,[1] provides a summary of the outcomes for people in the abstinence modality one year after treatment intake.

The abstinence modality is defined as: 'any structured programme which required individuals to be drug-free (including free from any pharmacological intervention) in order to participate in, and remain on, the programme'. Participants are required to attend a structured programme of daily activities and are given intensive psychological support. Abstinence-based treatment occurs in both inpatient and outpatient settings. Residential rehabilitation programmes can differ considerably in terms of their underlying philosophy and programme structure. Programmes may be either short-term (4–12 weeks) or long-term (3–12 months).

The ROSIE abstinence cohort comprised 82 individuals, the majority recruited from inpatient settings (85%, n=70), with the remainder being treated in outpatient settings (15%, n=12). Those recruited from inpatient settings were attending one of the three main types of residential rehabilitation programme identified in the international literature: 12-step/ Minnesota Model, Christian house or therapeutic community. The analysis presented in Findings 3 is based on the 56 participants who provided valid answers to each individual question during their treatment intake and one-year follow-up interviews.

The abstinence participants were typically male (89%), had an average age of 27 years and were largely dependent on social welfare payments (70%). Just less than half (47%) had children but the majority (77%) of these did not have their children in their care. Most had spent some time in prison (72%) and 16% had been homeless in the 90 days prior to treatment intake interview.

### Treatment completion rates

The treatment completion rate was high, with 66% of participants successfully completing their abstinence programme (n=37). Just over one-quarter of the cohort (27%, n=15) dropped out of treatment, 2% (n=1) transferred to another treatment type before completing the programme and the remaining 5% (n=3) were still engaged in their treatment programme at one year.

In addition to those still engaged in their abstinence treatment programme one year after treatment intake, 64% of participants (n=36) reported that they were in some form of drug treatment. Less than one-quarter of the cohort (23%, n=13) were on a methadone programme, 23% (n=13) were attending one-to-one counselling and 37% (n=21) were attending group work (Narcotics Anonymous (NA) meetings, aftercare programmes and structured day programmes).

### Drug use outcomes

The number of participants who reported using heroin, non-prescribed methadone, non-prescribed benzodiazepines, cocaine, cannabis or alcohol in the 90 days prior to interview decreased between treatment intake and one-year follow-up. The most substantial reduction was in cocaine use, in terms of the proportion of participants using the drug (46% at treatment intake compared with 14% at one year), the frequency of use (an average of 10 out of 90 days at treatment intake compared with an average of 2 out of 90 days at one year) and the quantities consumed (an average of 1 gram per day at treatment intake compared with an average of 0.3 grams per day at one year).

### Crime outcomes

Overall, the proportion of participants who reported no involvement in crime had risen considerably at one year (76%) compared to treatment intake (43%). There was a reduction in the percentage of participants involved in acquisitive crime, from 35% (n=19) at treatment intake to 13% (n=7) at one year.

### Risk behaviour outcomes

Findings 3 states that there was a non-significant reduction in the number of participants who reported injecting drug use. There were no changes in participants' injecting-related risk behaviours. The proportion of participants who reported an overdose within the previous 90 days remained at 4% (n=2) over the two time periods.

### Health outcomes

Ten symptoms were used to measure the physical health of participants (see paper for details). The number of participants who reported nine of the ten physical health symptoms reduced between treatment intake and one year.

## ROSIE Findings 3 *(continued)*

Ten symptoms were also used to measure the mental health of participants (see paper for details). There was a reduction in the number of participants who reported suffering from any five of the ten mental health symptoms.

### Service contact

Findings 3 reports an increase in participants' contact with GPs and with employment/ education agencies.

The authors state that the findings presented in this paper demonstrate that participation in an abstinence-based treatment programme is followed by positive outcomes in relation to drug use, involvement in crime, and physical and mental health symptoms. The outcomes for ROSIE participants in abstinence-based treatment compare favourably with international outcome studies. As noted in the paper, the forthcoming results from the ROSIE three-year follow-up will provide stronger evidence on the effectiveness of abstinence-based treatment programmes and on whether or not the improvements observed after one year will be sustained.

*(Sarah Fanagan)*

1. Cox G, Comiskey C and Kelly P (2007) *ROSIE Findings 3: Summary of 1-year outcomes: abstinence modality.* Dublin: National Advisory Committee on Drugs.

# 2007 National Drug Treatment Conference (UK)

The 2007 National Drug Treatment Conference was held in London on 15–16 March. Four major themes were addressed by the conference: social exclusion, poverty and drugs; detox and aftercare; legal and political issues for drug treatment; and new treatments.

Brian Iddon MP said we now need a war on the causes of drug misuse, namely social exclusion and poverty.

Mike McCarron, national drugs liaison officer for the Scottish Association of Alcohol and Drug Action Teams described the association between poverty and drug use and said that to tackle drug problems you have to deal with the underlying social issues. He admitted that to do this would take investment that some taxpayers might find unpalatable, but said he believed that if the facts were made available to them they would see that such investment was desirable in the long term. Brian Iddon MP spoke of the futility of a 'War on Drugs', and said we now need a war on the causes of drug misuse, namely social exclusion and poverty. He claimed that current drug policy merely caused displacement, whether of cocaine growers in South America who moved production from Columbia to other countries, or of users in the UK who switched from illegal drugs to prescription drugs which are easily available on the internet without regulation. He recommended that the current ABC classification of drugs should be abandoned and a system introduced that reflects a 50:50 split between harm to the user and harm to the general public. He cited a recent spectrum of harm developed by David Nutt and colleagues which ranks both alcohol and tobacco among the top ten most harmful drugs.

David Best of Birmingham University asked why people get so little treatment when we know it gives better outcomes, and why much of the treatment that is given is not sufficiently intensive. Referring to a study of more than 300 patients receiving counselling treatment, he demonstrated that the average fortnightly sessions, which also involved case management as well as advice and support on related issues such as housing and employment, often meant that clients only received just over 20 minutes of actual counselling a month, or around four hours a year. He spoke of the need to look for exits from treatment and to start thinking of addiction as a career with a beginning, middle and end, not as a permanent chronic condition. A number of speakers spoke about detoxification and its effectiveness in treating dependence on opioid and other illicit drugs, and of the need for optimum timing of a detoxification attempt within an addiction career.

The importance of commissioning integrated drug and alcohol systems was discussed by Trevor McCarthy of the National Treatment Agency (NTA). He said that fewer than half of drug users had been advised about alcohol during treatment, even though alcohol can dramatically increase depression of the immune system, as well as producing dangerous compounds; for instance, alcohol and cocaine produce cocaethylene when metabolised. Michael Farrell of the National Addiction Centre said that the problem of heavy drinking among those on maintenance prescribing is considerable and is estimated to occur in approximately 20% of the treatment population. He spoke of the need for treatment services to determine people's alcohol dependence. He also stressed the importance of being able to differentiate between opiate and alcohol withdrawal symptoms as ignorance could be fatal. Jack Law of Alcohol Focus Scotland spoke of the need to focus on harm reduction related to alcohol. He attributed problems with young people's drinking to increased acceptability, availability and affordability of alcohol. He said that harm reduction interventions would need to be pragmatic and strategic, looking more seriously at drinking environments, community safety initiatives, planning and effective licensing laws and better training of licensees.

*(Deirdre Mongan)*

Archived material from this conference (NDTC 07) and from previous events is available on the organiser's website at www.exchangesupplies.org

# Report proposes a new approach to working with drug users

In January 2007 Kilbarrack Coast Community Programme (KCCP) published a report entitled *Forging a new template: proposing a more effective way of working with drug users.*[1] Declan Byrne, the author of the report, has worked with KCCP since December 2000. He was awarded a masters degree in addiction studies from Dublin Business School (DBS) in 2005. This report is the culmination of his practical and academic experiences.

In a foreword to the report, Dr Rick Loose of DBS describes addiction and explains the importance of creating a transferential space in order to treat it. During treatment, addicts are asked to abstain from, or put a limit to, the substance they have been using. When asked to give up or reduce their intake of the problem substance which gives them pleasure (or stops pain), addicts will often come to depend on a substitute mechanism. Dependency on drugs or alcohol is transformed into a dependency on staff and/or the treatment centre. Addicts demand from the counsellor (or institution) something which drugs or alcohol had previously given them. They want to regain some of the lost immediacy or satisfaction via the transference relationship.

Addiction treatment relationships involve emotional expressions (demands for recognition, trying to please, being good, wanting to be loved, accusation, irritation, aggression, transgression, behaving badly etc.) which are signs of the pathology of the client. These emotional expressions are the essence of addiction treatment. The only way for addicts to recover is via verbalisation within a relationship where very difficult and anxiety-provoking experiences can be articulated and worked through.

It is in the very nature of addiction to undermine the pact that exists between people. This is what counsellors have to withstand and when this becomes problematic it can lead to counter-transference. It often happens that staff are idealised by addicts. At an unconscious level staff members may identify with this idealisation – there is a need in them to be admired by their clients. The treatment can become destructive if the counsellor's need feeds into the pathology of the client. This will lead to a therapeutic deadlock and the client will be forced to remain dependent on the counsellor/institution.

Loose argues that the creation and maintenance of a space of transference within society is essential. Popular culture advocates the immediacy of enjoyment which means that there is less space for dissatisfaction, desire and the social bond. This is the kind of culture that becomes less demanding of its subjects in terms of making them responsible for finding solutions to their own suffering and increasingly forces external solutions on them.

In the main body of the report, KCCP is used as a case study 'to demonstrate the need for change in the way we work with problematic drug users'. The varied lifestyles and circumstances of the programme participants are illustrated using the data from a general questionnaire administered to the 16 participants on the programme in March 2005. Detailed accounts of the experiences of three participants are provided by way of semi-structured interview, life history and treatment history. It is clear from these examples that the participants have different histories and reasons for taking drugs. As a result of his own work with clients and his reading of the academic literature (see report for details), the author advocates an approach to treatment in which the treatment programme is tailored to meet the needs of the individual, in so far as is possible. He highlights the necessity of working with the transference that occurs in the treatment of addiction and suggests that doing so could significantly increase the effectiveness of KCCP.

The author points out that KCCP will not be in a position to employ trained psychotherapists or psychoanalysts in the short to medium term. However, he suggests that a structured training programme could enable staff to manage the transference/counter-transference in order to help their clients. In June 2005 KCCP held a half-day training course on the issue of transference/counter-transference. This was seen as a first step in increasing awareness of the issue among staff. The author argues that the Health Service Executive (HSE) must take more responsibility for the running of community drugs programmes. 'By taking a more hands-on approach, they could ensure that all staff are professionally trained and that clinical supervision is provided.'

The author's proposed new template:

- The management of transference should be placed at the centre of KCCP's programme.
- Training in transference/counter-transference should be prioritised and funded for all staff working with clients.
- External supervision must be provided for staff.
- Additional funding should be sought to employ a psychotherapist to work with clients who have severe problems, particularly those with dual diagnosis and trauma histories.

*(Sarah Fanagan)*


1. Byrne D (2007) *Forging a new template: proposing a more effective way of working with drug users.* Dublin: Kilbarrack Coast Community Programme Ltd.

# *A key to the door* – Homeless Agency Partnership action plan 2007–2010


The Homeless Agency recently launched its action plan[1] to eliminate long-term homelessness[2] and the need to sleep rough[3] in Dublin by 2010. This article will discuss the elements of the plan that relate to homeless individuals with addiction problems in the context of the wider policy framework on drugs and homelessness.

The plan contains three strategic aims, relating to prevention, local access to quality homeless services and long-term housing options with support when required. The plan contains 10 core actions (high priority) that cover more than one strategic aim and 74 additional actions (lower priority). Individuals with mental health problems, addictions (alcohol and drugs) and dual diagnosis (addiction and mental health) needs have been identified as needing healthcare and other interventions as part of the strategic aim to prevent homelessness and reduce the risk of becoming homeless.

As part of the development of the action plan, a total of 105 men, women and children, both current and past users of homeless services, were interviewed. The principal immediate causes of their becoming homeless were identified by those interviewed as family breakdown, and alcohol, heroin and mental health problems. Several studies have shown the prominent role played by drug use in exposing individuals and families to homelessness in Ireland.[4,5,6,7]

When asked to comment on existing homeless and housing services, interviewees mentioned the shortage of treatment/detox beds, as well as the impossibility of giving up drink or drugs while on the streets. The importance of appropriate accommodation, including transitional housing, after treatment and/or detoxification was emphasised as a first step in relapse prevention. There were repeated calls for 'dry' hostels for homeless people wishing to be drug or alcohol free and 'wet' hostels for those unable or unwilling to remain abstinent.

By way of addressing some of these issues, the action plan states:

> *The Health Service Executive and National Drugs Strategy Team (with the Department of Community, Rural and Gaeltacht Affairs) will develop a national plan for the expansion of detox and rehabilitation services for active drug users, arising from the recommendations from consultations currently taking place. (p. 51)*

The issue of residential treatment capacity also arose during the recent deliberations of the Working Group on Drugs Rehabilitation. In response, the Health Service Executive (HSE) established a working group in September 2006 to examine the issue in depth. As an interim measure, the Working Group on Drugs Rehabilitation recommends an increase in the current stock of residential detoxification beds from 23 to 48.[8]

Also essential, in terms of relapse prevention and progress towards social reintegration, is the provision of transitional housing supports following treatment/detox and, indeed, this was stressed by those participating in the development of the action plan. Action 61 of the National Drugs Strategy identifies the need to provide a range of respite places and half-way houses.[9]

However, the mid-term review of the Strategy[10] noted that 'considerably more progress' was required on this action. Nonetheless, some efforts have been made to provide transitional housing for individuals coming out of residential treatment, for example those by Merchants Quay Ireland and the Arrupe Society. A pilot step-down housing programme, set up in 2005 in a partnership between Focus Ireland and the Keltoi project, is to be evaluated shortly. The recent report of the Working Group on Drugs Rehabilitation recommends that the Department of Environment, Heritage and Local Government take the lead in providing transitional and half-way housing for recovering drug users.

Individuals with mental health problems, addictions (alcohol and drugs) and dual diagnosis (addiction and mental health) have been identified in the Homeless Agency plan as needing healthcare and other supportive measures to prevent homelessness and reduce the risk of becoming homeless. Courtney (2005),[11] in a review of temporary accommodation services for homeless people, noted an increase in referrals of those with multiple needs, usually involving substance abuse and physical or mental health problems.

The Homeless Agency's action plan and *Preventing Homelessness*,[12] as well as the Report of the Working Group on Drugs Rehabilitation, emphasise the challenge of improving inter-agency working between the statutory, voluntary and community sectors in responding to the needs of individuals with addiction and accommodation problems. In addition, there is a requirement for structural changes to housing and accommodation provision, to cater for people who have been through the mental health and addiction services and are moving towards independent living. The challenge facing the Homeless Agency and its partners

## Homeless Agency Action Plan *(continued)*

in delivering on the strategic aim of providing long-term appropriate housing and supports is acknowledged in the plan:

> The success or failure of the Homeless Agency Partnership Action Plan is dependent on a dramatic increase over the next four years of secure and sustainable housing for people who are homeless. (p. 53)

*(Martin Keane)*


1. Homeless Agency (2007) *A key to the door: the Homeless Agency Partnership action plan on homelessness in Dublin 2007–2010.* Dublin: Homeless Agency.
2. Long-term homelessness is defined as the state of being homeless for over six months. For a definition of homelessness, see the Housing Act 1988, section 2.
3. The need to sleep rough occurs when there is a lack of emergency accommodation appropriate to a person's needs.
4. Houghton FT and Hickey C (2000) *Focusing on B&Bs: the unacceptable growth of emergency B&B placement in Dublin.* Dublin: Focus Ireland.
5. Feeney A, McGee H, Holohan T and Shannon W (2000) *Health of hostel-dwelling men in Dublin.* Dublin: Royal College of Surgeons in Ireland and Eastern Health Board.
6. Halpenny AM, Keogh AF and Gilligan R (2002) *A place for families? Children in families living in emergency accommodation.* Dublin: Homeless Agency.
7. Lawless M and Corr C (2005) *Drug use among the homeless population in Ireland: a report for the National Advisory Committee on Drugs.* Dublin: Stationery Office.
8. Working Group on Drugs Rehabilitation (2007) *Report of the working group on drugs rehabilitation, May 2007.* Dublin: Department of Community, Rural and Gaeltacht Affairs.
9. Department of Tourism, Sport and Recreation (2001) *Building on experience: National Drugs Strategy 2001–2008.* Dublin: Stationery Office.
10. Steering group for the mid-term review of the National Drugs Strategy (2005) *Mid-term review of the National Drugs Strategy 2001–2008.* Dublin: Department of Community, Rural and Gaeltacht Affairs.
11. Courtney R (2005) *Review of temporary accommodation.* Dublin: Homeless Agency.
12. Pillinger J (2006) *Preventing homelessness: a comprehensive preventative strategy to prevent homelessness in Dublin, 2005–2010.* Dublin: Homeless Agency.


# Young people's views on recreational facilities in East Cork

A recent report by McGrath and Lynch[1] highlights the lack of suitable recreational facilities and spaces for young people in East Cork. The report is based on a process of engagement with young people aged 13–18 attending secondary schools, youth projects and Youthreach, which included an exploratory survey, validation groups and a youth conference. The aim of this engagement process was to ascertain the views of young people on recreational facilities and spaces in East Cork.

The survey consisted of three questions that invited 'open responses'. A total of 702 young people responded to the survey. The researchers also conducted validation groups with some of the young respondents to discuss and develop some of the issues raised in the survey.

Seventy-nine per cent of the young people replied 'No' to the question 'Are there adequate recreational facilities in your area?' and, according to the authors, many replies were conveyed in emphatic terms using capital letters and exclamation marks. Replies included references to young people drinking alcohol, smoking tobacco and using other drugs to 'relieve boredom' in the absence of adequate facilities. Some replies highlighted the prohibitively high cost of using sports facilities and going to the cinema.

When asked 'When you go out, where do you go?', 82.2% replied that they 'hang around' with peers, often despite the disapproval of their parents. In elaborating further, 37.9% stated that they hung around the town centres and streets, 16% at friends' houses and 15.6% in shops or shopping centres.

When invited to identify what they would like to see happening in their areas for young people in the future, respondents said they would like more recreational facilities, including cinema, leisure centre/arcade, pool hall and restaurants (35.6%); sports facilities, including swimming pool and Astroturf (24%); and a place to 'hang around' (22.9%).

'Hanging around' with peers is a key theme throughout this research with young people, in terms of both what they do and what they need

## Views on youth facilities in East Cork *(continued)*

recreational space for. This theme of 'hanging around' as a particular need for young people is reflected in similar research and consultations with young people in Ireland. For example, 'hanging around' was identified as an important leisure activity by 90% of respondents in a survey of 2,260 12–18-year-olds from 51 schools in Ireland.[2] Research by Devlin[3] and Lalor and Baird[4] also highlighted 'hanging around' with peers as a favoured activity among young teenagers in Ireland. In addition, the report of the public consultation on the proposed national recreation policy for young people[5] identified the provision of more recreational facilities as the single biggest need identified, with somewhere to go and 'hang out' with friends the most requested recreational facility.

This report found that 'youth cafés' were a favoured option among young people as a place to 'hang out' with their peers.

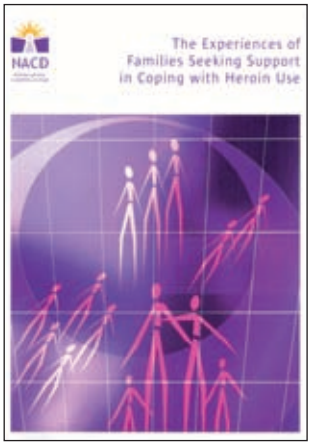
This report found that 'youth cafés' were a favoured option among young people as a place to 'hang out' with their peers. According to a recent report in the *Irish Times* (4 January 2007), the forthcoming national recreation policy for young people will include provisions for a network of youth café-type facilities throughout the country. It appears that what makes these youth cafés a popular option among young people is that they provide an alcohol and drug-free environment, they provide for unstructured 'hanging out' space, they are cheap to use and provide a safe space to mix with peers.

Two key messages emerging from this report reflect the findings of other Irish studies and the results of the public consultation on the proposed national recreation policy. First, the need for young people to be provided with adequate recreational space such as youth cafés to 'hang out' with their friends is one that parents, youth workers and policy makers can no longer ignore. The provision of additional recreational facilities, such as music or sports venues, can be developed in partnership with the young people from the initial reference of the youth café. Second, this a good opportunity for policy makers to take on board the findings from research and base their decisions on these findings. If, as seems likely, they respond to this challenge, the pursuit of evidence-based policy will have received a welcome boost.

*(Martin Keane)*


1. McGrath M and Lynch D (2007) *Where do you go when you go out? Young people's views on youth friendly facilities in East Cork.* Cork: East Cork Area Development Ltd.
2. de Róiste A and Dinneen J (2005) *Young people's views about opportunities, barriers and supports to recreation and leisure.* Dublin: National Children's Office.
3. Devlin M (2006) *Inequality and the stereotyping of young people.* Dublin: The Equality Authority.
4. Lalor K and Baird K (2006) *Our views – Anybody listening? Researching the views and needs of young people in Co Kildare.* Kildare: Kildare Youth Services.
5. Office of the Minister for Children (2006) *The report of the public consultation for the development of the national recreation policy for young people.* Dublin: Stationery Office.


# Families coping with heroin use




Launched on 4 April 2007, the report of research by the National Advisory Committee on Drugs (NACD) supports the inclusion of the families of heroin users in the overall treatment response. The main goal of this study by Duggan[1] was to develop a greater understanding of the ways in which families, and in particular primary carers, seek support in coping with heroin use in their families. The research also examined carers' expectations and perceptions of the effectiveness of the support provided.

The research used in-depth interviews with the primary carer, in most cases a parent, and usually the mother, in 30 families coping with heroin use. These were augmented by interviews with another family member in the case of seven families. The families were accessed through existing family support groups.

### Coping with heroin use in the family

The study identified seven different stages of families' engagement with heroin use in their family. The overall direction of this process was from powerlessness to empowerment. The different stages were:

1. Ignorance, confusion and denial
2. Coping alone
3. Desperately seeking help
4. Learning about heroin use and getting personal support
5. Supporting non-heroin-using family members
6. Supporting the heroin user in recovery
7. Supporting the community response to heroin use

# Families coping with heroin use *(continued)*

### Seeking help to cope with heroin use in the family

Three specific ways of interacting with services were identified, reflecting three different roles that families occupied. These were:

- As victims: non-heroin-using family members sought support for themselves in coping with the problems experienced due to heroin use in the family.
- As carers: families, particularly the primary carers, sought support for the heroin user.
- As agents of recovery: families sought to support the user into recovery and address their own needs as a family.

### Experiences of generic health services

Hospitals were complimented on their responses to the crisis needs of drug users, their children and other family members. However, interviewees reported that hospitals were poor in providing follow-up support or information on referral to support services.

Interviewees reported that general practitioners were often the first point of contact for family members seeking help. Responses from GPs varied, with some being of little assistance and others giving valuable information and advice to family members and, often, the heroin user. These responses demonstrate the need for standardised protocols governing the provision of information and support to families seeking help with heroin use through their GPs.

### Experiences of the criminal justice system

Families reported their contact with the criminal justice system to be ongoing and generally favourable. Gardaí in rural areas and judges were seen as sympathetic. The probation service was complimented for its constant and effective support for both the heroin user and the family.

### Experiences with specialist drug services

Drug counsellors were considered helpful and effective for both the heroin user and the family. Treatment centres were acknowledged for treating the user, but the effectiveness of the treatment was not always evident to the families. In addition, there was a perception among family members that treatment centres did not favour including the family in the treatment process and often maintained a distance from the family.

Families acknowledged the role played by methadone treatment in reducing anti-social behaviour among heroin users. However, in general, families were critical of methadone treatment services and were of the view that not enough information was provided about the implications of going on methadone. Families criticised the absence of alternative treatments and expressed the view that methadone maintenance programmes were not conducive to progression to abstinence and reintegration.

Community Drug Teams (CDTs) were highly regarded by those who reported contact with them; however, the view was expressed that CDTs should be available for longer hours and at weekends. Family support groups were also highly rated by families; contact with these groups often marked a turning point in empowering the families to respond to heroin use in their family.

### Barriers to accessing support

The stereotypical view of heroin use as a problem primarily associated with urban disadvantage often meant that rural families were slow to recognise the problem in their own families and less inclined to accept the problem as something prevalent in their communities.

When initially faced with the problem of heroin use by a family member, families often experienced shame and denial due to the perceived social stigma that surrounds heroin use. This had implications for the speed with which they sought help from external sources.

At almost every stage of coping with the problem of heroin use, family members were confronted with a lack of information on the type of help they needed, where they could access it and how they could assess its effectiveness.

This is an important and relevant piece of research as it identifies both the difficulties experienced by families seeking to cope with heroin use and access services and the positive role that families can play in the treatment of the heroin user. Clearly, families need better information and support when confronted with heroin use in their family. Also, specialist drug treatment providers, including general practitioners, need to consider the role that families can play in the treatment plans of clients.

### Report's key recommendations to policy makers and practitioners

- Recognise, value and resource the role of peer-led family support groups in assisting families in coping with heroin use.
- Deploy specialist personnel at local level to provide ongoing support to drug users and ongoing liaison with their families.
- Establish formal links between family support groups and drug treatment specialist personnel.
- All generic service providers should develop codes of practice in relation to information provision to families affected by heroin use.
- Acknowledge, in policy and practice, the spatial and social diversity of heroin use.

*(Martin Keane)*

1. Duggan C (2007) *The experiences of families seeking support in coping with heroin use.* Dublin: Stationery Office.

The probation service was complimented for its constant and effective support for both the heroin user and the family.

At almost every stage of coping with the problem of heroin use, family members were confronted with a lack of information.

# CityWide seeks new deal on drugs

On 16 April 2007 'Drugs – a new deal', a campaign calling for action by government and state agencies, was launched by CityWide, an organisation which supports a network of community groups throughout the country working to tackle the drugs problem. In its summary report of the launch[1] CityWide states: 'Despite the significant progress that has been made since the National Drugs Strategy (NDS) was first established in 1996, we now face a problem that is continuing to escalate and that is damaging the lives of more and more people, more and more families, more and more communities'. The report proceeds to call for a 'new deal to be put in place between the government, the state and local communities that recognises the scale and seriousness of the problem that is facing us all'. The 'Drugs – a new deal' campaign makes seven key demands of central government. These are listed in the summary report:

- **'Implement the National Drugs Strategy 2001-2008.'** According to CityWide, key commitments given as part of the NDS have not yet been met. The organisation wants 'an immediate plan on how to fast track the implementation of all remaining actions'.
- **'Reinstate a full-time Government Minister with sole responsibility for the National Drugs Strategy.'** As reported on p. 1, the new Minister of State appointed on 20 June, Pat Carey TD, has responsibility for drugs strategy and community affairs, both included within the one ministerial portfolio.
- **'Make adequate budgets available to both Local Drug Task Forces (LDTFs) and Regional Drug Task Forces (RDTFs) for the development of drug services to respond to the crises in both heroin and cocaine use.'** According to CityWide, the budget for 2007 allocated no additional funding for the provision of new services in LDTF areas, despite what it refers to as 'the growing cocaine problem, as highlighted in the recent NACD report,[2] and the continuing heroin crisis'.
- **'Make available an immediate budget for the implementation of recommendations in the Rehabilitation Report.'** A rehabilitation report was published in early June by the Department of Community, Rural and Gaeltacht Affairs. It makes recommendations for the development of rehabilitation services for drug users. CityWide is calling for adequate resources to be set aside to fund these recommendations.
- **'Implement immediately the action on setting up local Community Policing Fora.'** According to CityWide, people living in local communities affected by drug use have serious concerns around issues of personal safety and security. CityWide claims that the NDS provides for the establishment of Community Policing Fora (CPF) in 14 areas, but to date only three have been put in place.[3] The organisation is calling for the remaining CPFs to be established.
- **'Commit to working in full partnership with local communities that are devastated by the drugs crisis.'** CityWide claims that in recent years there has been an 'undermining of the local structures by central government', and states that the government needs to display ' a commitment to re-engaging the community again, as happened in 1996'.
- **'Provide support for families to be involved as partners at LDTF and RDTF.'** CityWide claims that 'family members have been among the most active members of the community in responding to the drugs crisis', and they state that this contribution from families 'needs to be recognised through their involvement in the local structures'.

In the run-up to the recent general election, CityWide called for whatever party was elected to government to give an urgent political response to the drugs crisis. Speaking at the launch were a number of prominent politicians, including the Labour Party leader Pat Rabbitte TD, Fine Gael TD Damien English, Sinn Fein TD Aengus O Snodaigh, Socialist Party TD Joe Higgins and Independent TD Finian McGrath. The government was represented by Fianna Fáil senator, Cyprian Brady.

Issues raised at the launch included the increased prevalence of both cocaine and benzodiazepines within communities and the associated problems. The problem of alcohol misuse was also mentioned, as was the issue of waiting lists for methadone maintenance, with particular reference to the Ballyfermot area.

*(Johnny Connolly and Angela Morgan)*

1. CityWide (2007) Summary of 'Drugs – a new deal' campaign launch. Retrieved 4 May 2007 from www.citywide.ie/resources/pubs/20070326162045.html
2. National Advisory Committee on Drugs and the National Drugs Strategy Team (2007) *An overview of cocaine use in Ireland: II.* Dublin: Stationery Office.
3. CityWide (2007) *Election 07: drugs in local communities.* Retrieved 4 May 2007 from www.citywide.ie/download/doc/election_07.doc

# Dóchas Centre: process evaluation and treatment outcome study

In March 2006 the HSE published the results of an 18-month long process evaluation and treatment outcome study of female drug-using prisoners admitted to the Dóchas Centre, Mountjoy Prison, Dublin.[1] Dr Catherine Comiskey, the principal investigator, presented the main findings of the study in the offices of the Women's Health Council.

The aim of the study was to model the care pathway of the women and to discover whether their experiences in the Dóchas Centre had a positive or negative impact on their lives. Forty drug-using women admitted to the Dóchas Centre between May 2003 and January 2004 were recruited to take part in the longitudinal survey. The women were interviewed within one month of committal and again six months later. Qualitative interviews were also conducted with eight participants working in a number of capacities with women who had been in prison.

Of the original cohort of 40 women who participated in baseline interviews, outcome data was obtained for 39 women and 27 women completed a second interview. The women ranged in age from 16 to 43 years; 23 had children under the age of 18, most of whom did not live with their mothers. The majority of the women had completed their education by the age of 15. The main findings of the report are outlined below.

The study measured key variables, including drug use, accommodation, health, psychosocial functioning and involvement in crime before the women were admitted to the Dóchas Centre, during their imprisonment and after their release. The strongest positive outcomes were in the area of crime. There was a significant reduction in the overall proportion of women committing crimes between baseline interview and six-month follow-up. The one exception to this was the crime of soliciting, with results at follow-up indicating a slightly increased incidence.

There were varying improvements in the extent of drug use among the sample population. The most positive of these was a significant reduction in the levels of heroin use. On average, the women who were using heroin at recruitment stage were using it at least once a day. At six-month follow-up this had reduced to twice a week. Slight reductions were also noted in the numbers of women using cocaine, non-prescription methadone and ecstasy. The physical and mental health of the women showed only minor improvements at follow-up and, in some cases, there was evidence of deterioration. Of particular concern was the finding that three of the women interviewed had attempted suicide since leaving prison.

One of the main findings of this study was that the women were exposed to considerable risks upon their release from the Dóchas Centre. The women's experiences on release included overdose, gang rape, prostitution, homelessness and polydrug use. Of the 22 women who were released from prison during the six-month follow-up period, only seven returned home and did not report any trauma. Three of the original cohort of 40 women died during the six-month follow-up period. All three of these women had been released from the Dóchas Centre. This finding demonstrates the real and significant risks associated with the period following the release of female drug-using prisoners.

The majority of women who were interviewed at six-month follow-up felt that the time which they spent in the Dóchas Centre had been of some help. The ways in which the prison helped varied for each woman and included assistance with drug treatment, educational opportunities and a break from the stress of their lives. Despite these positive experiences, the women expressed a number of negative criticisms of the services they received. Over half of the women had concerns at the time of their release relating to, for example, a lack of suitable accommodation, money worries, concerns surrounding their children and a fear of returning to drug use. The women were asked whether they had received help with these issues upon being released. Of the 20 women who answered the question, only three had received assistance. In addition to this, only four of the 27 women interviewed at follow-up stated that they had had any contact with social welfare services while in prison. Finally, 16 of the 22 women who were released during the time between baseline interview and follow-up were not given advanced indication of their release date, which had implications for the women's vulnerability to risks upon release.

A key finding that emerged from the qualitative interviews with the eight participants who worked with women who had been in prison was the lack of co-ordination between the various in-reach services to the women's prison. These participants felt that, while the current range and number of agencies providing in-reach services was sufficient, the lack of integration between the services often resulted in poorer outcomes for the women. They stressed the need for appropriate accommodation that took into account the specific requirements of drug-using women who had been in prison.

The findings of the study indicate that the women experienced some positive effects in their lives in the six-month period between recruitment and follow-up interviews. It is unclear whether the improvements noted in the report can be attributed to the Dóchas Centre or to the stage which the women were at in their drug-using careers. The authors suggest that further longitudinal information on the women and their care processes would be required in order to clarify this.

*(Sinéad Foran)*


One of the main findings of this study was that the women were exposed to considerable risks upon their release from the Dóchas Centre.

1. Comiskey CM, O'Sulllivan K and Cronley J (2006) *Hazardous journeys to better places.* Dublin: Health Service Executive.

# Identifying new drugs and new drug trends with the help of drug helplines

In February 2007 the European Foundation of Drug Helplines (FESAT) published the results from its twelfth monitoring project.[1] Since the beginning of 2001 FESAT has been collecting information every six months on the types of person contacting helplines, the content of these calls and how this has changed compared to the previous six months. According to the author, the main objective of this monitoring is to identify the emergence of new drugs and new drug trends; the data cannot quantify the size of any such changes.

Of the 35 relevant FESAT helplines, 18 helplines in 14 European countries, including Ireland, participated in the project. This article will describe some of the main changes that were reported by the helplines in Europe during the first half of 2006 when compared to the second half of 2005. The article presents some unpublished information from the Drugs/HIV Helpline in Ireland.

The smallest of the 18 participating helplines in Europe answered an average of one call per day, and the largest, 130. Seven helplines answered 10 calls or fewer per day; eight helplines answered 11 to 30 calls; one helpline answered 31 to 60 calls and two helplines answered 61 or more calls. The Drugs/HIV Helpline in Ireland answered an average of 16 calls per day, though this figure included calls about sexual health. There were 2,125 calls between January and July 2006 which represents a 6% decrease when compared to the preceding six-month period (Aileen Dooley, personal communication, 2007).

The FESAT report notes a continuation of the upward trend in the numbers of calls about cocaine (8 helplines) and about alcohol (6 helplines) across Europe. There were increases also in the numbers of calls about cannabis and ecstasy. There were decreases in the numbers of calls about injecting heroin and magic mushrooms.

In Ireland, there was some decrease in the number of calls to the Drugs/HIV Helpline about cocaine, from 257 in the second half of 2005 to 226 in the first half of 2006. The number of calls about alcohol remained unchanged at an average of 235 calls for each reporting period. There was some decrease in the number of calls about cannabis, and a large decrease in the number of calls about magic mushrooms in the first half of 2006 when compared to the second half of 2005. There was some increase in calls about ecstasy in the first half of 2006. (Aileen Dooley, personal communication, 2007)

During the first half of 2006, three helplines in Europe received calls about drugs that had not been reported to them before. A helpline in Greece reported a call about a substance called 'Mothball' but did not describe its appearance or its effect. The helpline in the Netherlands reported calls about two new drugs, Original 69 and Ethyltryptamine. Original 69 is a blue liquid (containing MDMA and amphetamine) presented in 25 ml bottles and usually sold to people attending parties; this liquid has a similar effect to ecstasy. Ethyltryptamine is a pill which has hallucinogenic effects. The Norwegian helpline reported calls about methamphetamine and Ayahuasca. Methamphetamine has been reported by helplines in other countries. Ayahuasca is a tea made from plants; its use may result in neurotic or psychotic episodes. The Drugs/HIV Helpline in Ireland did not report calls about any new drugs.

*(Jean Long)*

1. Hibell B (2007) *FESAT Monitoring Project – Changes during the first half of 2006.* Brussels: FESAT (The European Foundation of Drug Helplines).

More information about FESAT can be found on the website of the European Foundation of Drug Helplines at www.fesat.org

**The Drugs/HIV Helpline in Ireland is a confidential, freephone, active listening service offering non-directive support, information, guidance and referral to anyone with a question related to substance use or HIV and sexual health. Set up in July 1997, the service is funded and managed by the Health Service Executive.**

**The freephone number is 1800 459 459. The Helpline manager is Aileen Dooley.**

# Suboxone licensed in Europe

On 24 February 2007 the combination drug Suboxone[1] was launched in Ireland. The Department of Health has established an expert group to consider the implications of the introduction of this drug and its use as a treatment for opiate dependency. In order for this drug to be prescribed, a system similar to that existing for methadone, including a protocol and a central register, will be required.

Made by Schering Plough, Suboxone is taken by placing the pill under the tongue and allowing it to dissolve. The product contains two active ingredients – buprenorphine, a partial opiate agonist, which helps manage the cravings associated with opiate withdrawal, and naloxone, an opiate antagonist, which prevents overdose if the drug is injected. Suboxone tablets are available in two strengths (containing either 2 mg or 8 mg of buprenorphine). The naloxone content is one-quarter that of the buprenorphine content. This drug is taken daily. Since Suboxone is eliminated through the liver, the dosage needs to be lowered for people with mild or moderate liver dysfunction. This drug is not recommended for people with severe liver dysfunction. According to the producers, Suboxone should not be used during pregnancy. If a woman becomes pregnant while on Suboxone treatment, she should be changed to another opiate substitute. The respiratory depressant effect of Suboxone is amplified when the drug is consumed with alcohol or benzodiazepines.

The introduction of Suboxone to Ireland provides another choice of treatment for problem opiate use, as well as an opportunity to identify which substitute is most suitable for different sub-groups of patients.

*(Jean Long)*

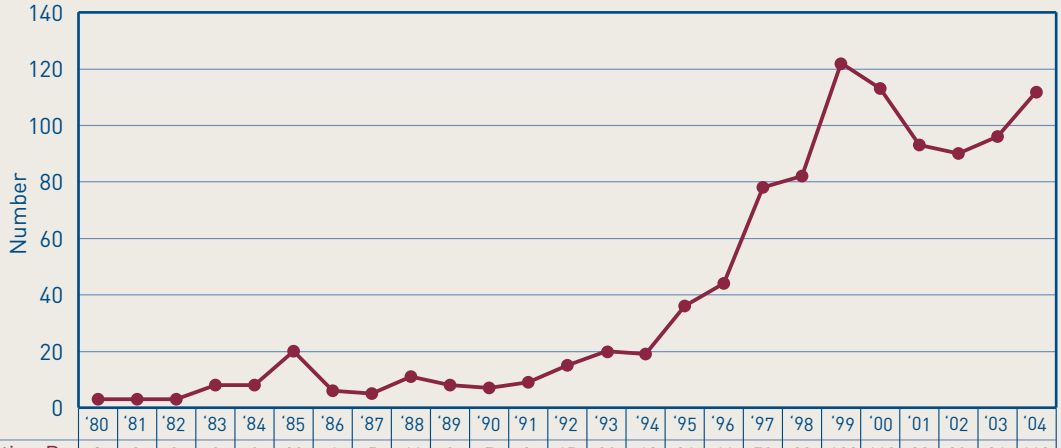
1. European Medicines Agency (2006) *Suboxone: Summary of product characteristics.* Retrieved April 2007 from www.emea.eu.int/humandocs/PDFs/EPAR/suboxone/H-697-PI-en.pdf

# Update on direct drug-related deaths in Ireland

Problem drug use can lead to premature death. Deaths can occur as a result of overdose (both intentional and unintentional), actions taken under the influence of drugs, medical consequences and incidental causes. Drug-related deaths and mortality among drug users are indicators of the consequences of problem drug use in Ireland.

The data presented in this article provide the number of direct drug-related deaths between 1980 and 2004, based on unpublished data from the Central Statistics Office (CSO). Direct drug-related deaths are those occurring as a result of overdose. At the European level, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has developed a standardised method for extracting data on drug-related deaths from the mortality registers in all member states.[1] Staff at the CSO [2] extracted and collated the data in February 2007, using the EMCDDA's 'Selection B' definition of drug-related death.

Figure 1 presents the numbers of direct drug-related deaths in Ireland between 1980 and 2004, extracted




| | '80 | '81 | '82 | '83 | '84 | '85 | '86 | '87 | '88 | '89 | '90 | '91 | '92 | '93 | '94 | '95 | '96 | '97 | '98 | '99 | '00 | '01 | '02 | '03 | '04 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ● Selection B | 3 | 3 | 3 | 8 | 8 | 20 | 6 | 5 | 11 | 8 | 7 | 9 | 15 | 20 | 19 | 36 | 44 | 78 | 82 | 122 | 113 | 93 | 90 | 96 | 112 |

**Figure 1 Number of direct drug-related deaths in Ireland reported by the CSO, 1980 to 2004 (unpublished data from the vital statistics)**

## Update on drug-related deaths *(continued)*

Between 2001 and 2004, 60% of direct drug-related deaths were opiate-related.

from the General Mortality Register. There were few such deaths in the 1980s. Between 1990 and 1994, there was a small but steady increase in the number of drug-related deaths, and between 1995 and 1999 a substantial increase. This was followed by a considerable decline in the number of deaths between 2000 and 2002. In 2003, the number of drug-related deaths increased marginally when compared to 2001 and 2002, with a further increase in 2004.

Between 2001 and 2004, 60% of direct drug-related deaths were opiate-related. In 2000 two (1.8%) drug-related deaths were due to cocaine alone; this increased to nine (8%) in 2004. The coding system used does not allow one to extract data on cocaine and other drugs combined, therefore these figures are an underestimate of cocaine-related deaths.

Figure 2 presents the numbers of direct drug-related deaths in Dublin and in the rest of Ireland between 1980 and 2004.

According to data from the General Mortality Register, almost all direct drug-related deaths between 1980 and 1994 occurred in Dublin. Between 1995 and 1999, there was a substantial increase in such deaths in Dublin, from 33 to 96, and a steady increase outside the Dublin area, from 3 to 26.

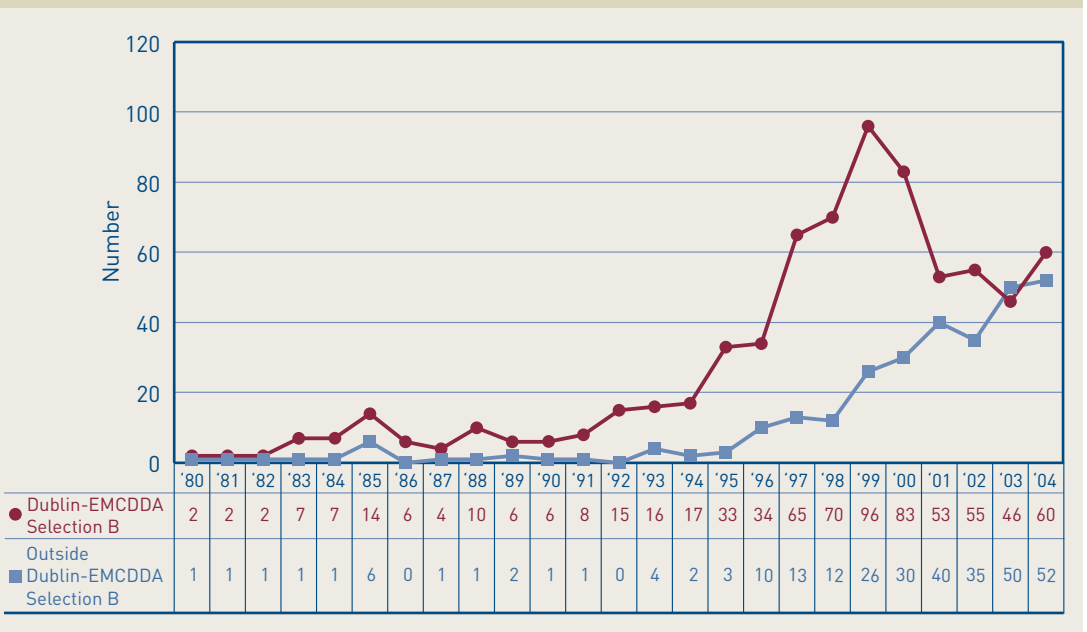
During the period 2000 to 2004, there was a continued increase in drug-related deaths outside Dublin, from 30 in 2000 to 52 in 2004.

Between 2000 and 2003, there was a sharp decline in direct drug-related deaths in Dublin, from 83 to 46. Between 2003 and 2004, there was a considerable increase, from 46 to 60 drug-related deaths. This is the first year such an increase has been reported in Ireland since 1999. This trend has been reported in other European countries. Factors contributing to this trend may include, in addition to the increase in cocaine-related deaths mentioned above, the ageing population among drug users and an increase in both the availability and purity of heroin reported in Europe generally.

During the period 2000 to 2004, there was a continued increase in drug-related deaths outside Dublin, from 30 in 2000 to 52 in 2004. In 2003, the number of such deaths outside Dublin exceeded for the first time the number in Dublin; however, the trend reversed in 2004, with more drug-related deaths reported in Dublin than outside Dublin. The data for outside Dublin follow trends in problem opiate use in that geographical area.

*(Ena Lynn, Jean Long and Lorraine Coleman)*

1. EMCDDA (2002) *The DRD-Standard, version 3.0: EMCDDA standard protocol for the EU Member States to collect data and report figures for the key indicator drug-related deaths by the standard Reitox tables.* EMCDDA project CT.02.P1.05. Lisbon: European Monitoring Centre for Drugs and Drug Addiction.
2. The authors would like to thank Joseph Keating at the Central Statistics Office for extracting and collating the data on direct drug-related deaths from the General Mortality Register.




| | '80 | '81 | '82 | '83 | '84 | '85 | '86 | '87 | '88 | '89 | '90 | '91 | '92 | '93 | '94 | '95 | '96 | '97 | '98 | '99 | '00 | '01 | '02 | '03 | '04 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Dublin-EMCDDA Selection B | 2 | 2 | 2 | 7 | 7 | 14 | 6 | 4 | 10 | 6 | 6 | 8 | 15 | 16 | 17 | 33 | 34 | 65 | 70 | 96 | 83 | 53 | 55 | 46 | 60 |
| Outside Dublin-EMCDDA Selection B | 1 | 1 | 1 | 1 | 1 | 6 | 0 | 1 | 1 | 2 | 1 | 1 | 0 | 4 | 2 | 3 | 10 | 13 | 12 | 26 | 30 | 40 | 35 | 50 | 52 |

**Figure 2 Number of direct drug-related deaths in Ireland, by plac of death, reported by the CSO, 1980 to 2004 (unpublished data from the vital statistics)**

# National Registry of Deliberate Self Harm – annual report 2005


The fifth annual report from the National Registry of Deliberate Self Harm was published in March 2007. The report contains information relating to each episode of deliberate self-harm from persons presenting to all general hospital A&E departments and two of the three paediatric hospital A&E departments in Ireland in 2005. The Registry defines deliberate self-harm as 'an act with non-fatal outcome in which an individual deliberately initiates a non-habitual behaviour, that without intervention from others will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes that the person desires via the actual or physical consequences'.[1]

The report concludes that there were 10,789 presentations of deliberate self-harm, involving 8,594 individuals, to hospital A&E departments in 2005. The number of presentations was 3% lower than in 2004, when there were 11,092 presentations by 8,610 individuals. The age-standardised rate of deliberate self-harm was 198 per 100,000, compared with 201 per 100,000 in 2004, representing a 2% decrease. The national rate in 2005 was 37% higher among females than among males, at 230 per 100,000 and 167 per 100,000 respectively. Forty-six per cent of all presentations were by persons less than 30 years of age, and 87% by persons less than 50 years of age. The peak age range for females presenting was 15–19 years, at 606 per 100,000. The peak age range for males presenting was 20–24 years, at 392 per 100,000. There was evidence of alcohol consumption in 41% of all episodes of deliberate self-harm.

Drug overdose was the most common form of deliberate self-harm, representing 76% of all such episodes (7,751 episodes). Overdose rates were higher among females (82%) than among males (67%). On average, 31 tablets were taken in episodes of drug overdose. The total number of tablets taken was known in 80% of cases. Forty-one per cent of all drug overdoses involved a minor tranquilliser, 32% involved paracetamol and 23% involved anti-depressants.

Self-cutting was the second most common method of deliberate self-harm, representing 21% of all episodes. In contrast to drug overdoses, self-cutting was more common among males than among females.

Repetition of deliberate self-harm accounted for 20.5% of all presentations in 2005. Cutting and attempted hanging were methods of self-harm associated with an increased level of repetition.

The report recommends the following measures to reduce the incidence of deliberate self-harm:

- a comprehensive mental health awareness campaign to reduce levels of psychiatric and psychological morbidity in the population
- additional resources to support mental health promotion, and specialist mental health services for adolescents aged 15–19 years
- evidence-based interventions targeting persons who repeatedly self-harm
- a mechanism for linking data collected by the Registry with data on suicide mortality to improve understanding of the relationship between deliberate self-harm and the risk of suicide in the future
- extension of the core Registry dataset to support evaluation of progress on actions in the strategy document on suicide prevention, *Reach Out*.[2]

*(Lorraine Coleman and Ena Lynn)*

**Drug overdose was the most common form of deliberate self-harm, representing 76% of all such episodes (7,751 episodes).**

1. National Registry of Deliberate Self Harm Ireland (2007) *Annual Report 2005.* Cork: National Suicide Research Foundation.

2. HSE, National Suicide Review Group and Department of Health and Children (2005) *Reach Out: National Strategy for Action on Suicide Prevention 2005–2014.* Dublin: Health Service Executive.

# Find out who's doing what in alcohol and drug research

Anyone with access to the Internet can now find out at the click of a mouse who's doing what in problem alcohol and drug use research in Ireland. The National Documentation Centre on Drug Use (NDC) is compiling an online register of current research and evaluation (CRED) in the area of drug use, problem alcohol use and related fields in Ireland. The NDC is also compiling a Directory of Researchers and Evaluators currently conducting research in these fields.

NDC staff identify research projects by contacting all major research and evaluation institutions, researchers and evaluators in the field of drug misuse, and by searching relevant websites. The CRED database records the title of each project, its aims, the research or evaluation methods used, the names of commissioning bodies, funding details and the names of the researchers and evaluators involved in the project. The database only includes details of current projects. Completed projects will be placed in an archive and will no longer be publicly displayed. The aim of CRED is to provide a comprehensive overview of ongoing research in the area of alcohol and drug use.

CRED is an important tool for researchers and evaluators as it can help:

- increase awareness of the work they are doing among a wide audience
- identify individuals working in areas of mutual interest
- find other similar projects and minimise duplication of effort
- streamline the search for relevant information
- identify potential funders and commissioning bodies.

Once a contributor registers with this service they can submit their own projects, update them and edit their profiles at their ease. This database is a growing resource and we will continue to add new or existing projects as we receive them. We welcome on-line submissions of suitable material for inclusion in this database. Please contact mnelson@hrb.ie for further information, or visit our website at www.ndc.hrb.ie

*(Mairea Nelson)*

# Ana Liffey strategic plan 2007–2011

Eoin Ryan MEP launched *Now & Next*, the Ana Liffey Drug Project strategic plan for the next five years on 15 June 2007.

**From left: Eoin Ryan MEP and Tony Duffin, director of the Ana Liffey Drug Project, at the launch of *Now & Next* (Photo: Jim Berkeley)**


*Now & Next: ADLP strategic plan 2007–2011* can be downloaded from the Resources page of the Ana Liffey website at www.aldp.ie.

# In brief

On 8 February 2007 **benzylpiperazine (BZP)** was the subject of a written answer in Dáil Éireann from the Minister for Health and Children, Mary Harney TD: 'A risk assessment is being carried out at EU level on BZP. This engages the relevant experts across the EU to assess the possible health and social risks/consequences of the identified substance and the implications of placing it under control. The results of the risk assessment will be presented to the Council, the European Medicines Agency and the Commission for a decision on whether BZP should be subjected to control measures. Control measures and penalties are decided according to national laws which in turn comply with UN conventions.' www.oireachtas.ie

On 7 March 2007 the **Irish Society for the Prevention of Cruelty to Children (ISPCC)** published its Childline Annual Call Statistics for 2006. Among its telephone calls, 1,993 (1.55%) were in regard to child substance use and abuse. Among contacts via the website, three (1.42%) were about child substance use and abuse. www.ispcc.ie

On 15 March 2007 **Ana Liffey Drug Project,** Ireland's first harm reduction agency, celebrated its 25th anniversary, with a half-day conference. www.aldp.ie

On 27 March 2007 the **Joint Committee on Arts, Sports, Tourism, Community, Rural and Gaeltacht Affairs** released its 12th and 13th reports. ***Drug abuse in Ireland – a Waterford perspective*** finds that the majority of people seeking help for addiction in the Waterford constituency are using more than one drug, with alcohol and hash being by far the most popular cocktail for almost two thirds. A history of addiction in the family is overwhelmingly prevalent. ***The relationship between alcohol misuse and the drinks industry sponsorship of sporting activities*** explores the links between sponsorship of sports by alcohol companies and the risk to people, especially young people, through misuse of alcohol. The report attempts to assess the effectiveness of a ban on such sponsorship and explores the related issues. www.oireachtas.ie

In March 2007 the **International Drug Policy Consortium (IDPC)** released its 4th briefing paper, ***The European Union Drug Strategy: progress and problems.*** Despite progress, the briefing reports that current evaluation data suggest that drug use in Europe is only being contained at best and, despite several successes in reducing the harmful consequences, problems such as drug-related crime, drug-related deaths, and rates of hepatitis infection among drug injectors remain unacceptably high. The IDPC suggest ways in which the current EU strategy and actions could be strengthened. www.internationaldrugpolicy.net

In March 2007 the **RSA Commission on Illegal Drugs, Communities and Public Policy** published a report on its two-year study of UK drug policy. It calls for a radical rethink of drugs policy, drawing it away from criminal justice and refocusing it on health and social support. Claiming that the Misuse of Drugs Act 1971 is 'no longer fit for purpose', the Commission calls for a new Misuse of Substances Act, to include alcohol, tobacco, solvents, and over-the-counter and prescription drugs. www.rsadrugscommission.org

On 5 April 2007 **Barnardos** launched its ***Children's Declaration – A million reasons to get it right.*** Among the key action points advanced in the Declaration is the following: 'Given the strong connections between alcohol abuse and drug abuse, the National Alcohol Strategy and National Drugs Strategy should be reviewed with the view of identifying key areas where both strategies can be integrated to reinforce each other – both national plans are currently being administered separately.' www.barnardos.ie

On 16 April 2007 **CityWide Drugs Crisis Campaign** launched a campaign in the run-up to the general election entitled 'Drugs: a new deal'. www.citywide.ie

On 19 April 2007 the **UK Drug Policy Commission (UKDPC)** was launched along with its first report, ***An analysis of UK drug policy,*** by Peter Reuter and Alex Stevens. The UKDPC is an independent body set up to provide objective analysis of UK drug policy. The Commission aims to improve political, media and public understanding of drug policy issues and the options for achieving a rational and effective response to the problems caused by the supply of and demand for illegal drugs. www.ukdpc.org

On 26 April 2007 ***Mental Health Awareness and Attitudes Survey January/February 2007*** was launched. Suicide, alcoholism, depression and drug dependence are believed to be the most important mental health and related problems we need to tackle in Ireland. www.nosp.ie

On 27 April 2007 **Merchants Quay Ireland** hosted a pre-election debate on drugs issues in Ireland, entitled 'Drugs: the politicians' prescription'. www.mqi.ie

In April 2007 the **Irish College of General Practitioners (ICGP)** announced that its Methadone GP Co-ordinator, Dr Ide Delargy, is extending her services to GPs outside the former ERHA area. She will act as a resource for GPs already involved in prescribing methadone under the protocol, and will aim to increase the number of GPs participating in the protocol throughout the country. GPs can reach Dr Delargy on 01-230-2659 or 086-810-0803 or at iddelargy@eircom.net www.icgp.ie

In April 2007 **ENCOD (European Coalition for Just and Effective Drug Policies)** released its 2006 annual report. In 2007 ENCOD has set itself the challenge of obtaining a meaningful and transparent dialogue with authorities of the European Union; it reports that the European Commission has promised to initiate a dialogue process with civil society concerning drug policies in the second half of the year. Additionally, ENCOD will co-ordinate the preparation of the campaign for the UN meeting in March 2008 in Vienna. www.encod.org

*(Compiled by Brigid Pike)*

# *Drugs in focus* – policy briefing

**No. 15: Hallucinogenic mushrooms: the challenge of responding to naturally occurring substances in an electronic age**

This policy briefing, No 15 in the *Drugs in focus* series issued by the EMCDDA, reviews information on the use of hallucinogenic mushrooms in Europe and draws lessons to inform policy.

Naturally occurring hallucinogens can be found in over 100 species of mushroom, most of which contain psilocybin and psilocin as the main ingredients responsible for the hallucinogenic effect. These ingredients are controlled at the highest level internationally, but there is a lack of legal clarity in some countries with regard to mushrooms containing these substances. This confusion has been exploited by mushroom retailers and has presented obstacles to the development of mechanisms to control supply.

Among the key points made in this briefing are:

- Among young people aged 15 to 24 years in 12 EU Member States, the proportion who have ever used hallucinogenic mushrooms ranges from less than 1% to 8%. Their use is more common among young people who have used other illegal drugs than among young people who have not.
- The sale of hallucinogenic mushrooms by 'smart' shops and market stalls in the Netherlands and the UK appears to have played an important role in facilitating their use.
- A recent internet search identified 39 online shops that sell hallucinogenic mushroom products. Considerable variation was noted in the extent and quality of information provided about the health risks of the products sold.
- The reported number of fatal and non-fatal emergencies from hallucinogenic mushroom use is very low. In general, the physiological effects are short-lasting and not significant; it is more commonly linked to mental health risks and, in a significant number of cases, to panic attacks.
- The unpredictable effects of these mushrooms, and social constraints on young experimenters, may act as barriers to regular or frequent use.
- Six EU countries, including Ireland, have tightened their legislation on mushrooms since 2001 in response to concerns about the prevalence of use. There are signs that online retailers have responded by switching to uncontrolled and, in some cases, more toxic alternatives.
- There appears to be a gap in the provision of mushroom-specific information material for professionals working with young people and a similar lack of prevention or harm reduction material aimed at potential users.

***Drugs in focus*** is a series of policy briefings published by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The briefings are available on the EMCDDA website at www.emcdda.europa.eu

If you would like to receive a hard copy of the current or future issues of *Drugs in focus,* please contact: Alcohol and Drug Research Unit, Health Research Board, Knockmaun House, 42–47 Lower Mount Street, Dublin 2.
Tel: 01 2345 127
Email: adru@hrb.ie

# From *Drugnet Europe*

**Broader remit for EMCDDA**
*Cited from* Drugnet Europe *No. 57, January–March 2007*

The revised EMCDDA regulation [EC Regulation No. 1920/2006] adopted by the European Parliament and the council of the EU … broadens the scope of the Centre's tasks, granting it a more active role in monitoring new methods of drug use and related trends. Specifically, it allows the agency to collect, register and analyse information on 'emerging trends in polydrug use', including the combined use of licit and illicit psychoactive substances.

A key aspect of the new remit is providing information on best practice in the EU Member States and facilitating exchange of such practice between them. …the EMCDDA may also be called on to transfer its know-how to certain non-EU countries, such as official candidates for EU accession and countries in the Western Balkans. This is likely to entail creating and reinforcing links with the Reitox network and assisting in the building and strengthening of national focal points.

The Centre's own administration is also being overhauled, with the Management Board (on which all Member States and other stakeholders are represented) to be assisted by a new six-member Executive Committee to prepare the decisions of the Board and to advise the Director. …the existing Scientific Committee is being slimmed down to a maximum of 15 members to be chosen through a public selection process based on scientific excellence and independence.

# From *Drugnet Europe (continued)*

### Progress review — EU drugs action plan (2005–2008)

*Cited from Frank Zobel* Drugnet Europe *No. 57, January–March 2007*

The European Commission released on 21 December the first progress review on the implementation of the EU drugs action plan (2005–2008) [SEC(2006) 1803]. Covering the 18-month period from the plan's adoption on 27 June 2005 to December 2006, the report assesses to what extent activities foreseen for this period have been implemented and their objectives reached.

In the report's conclusions, issues outlined as requiring closer attention include: a better coordination between public health and law-enforcement bodies at all levels; more realistic and feasible indicators for some actions; and the involvement of civil society in forthcoming reviews in the context of the Commission's 'Green Paper on the role of civil society in drugs policy in the European Union'.

### EMCDDA strategy and work programme (2007–2009): A sound framework for drugs monitoring in Europe

*Cited from* Drugnet Europe *No. 57, January–March 2007*

Working more efficiently, investing more in analysis and communicating more effectively with key audiences are among the goals of the EMCDDA's new work programme (2007–2009). Adopted by the Management Board in 2006, the programme charts the agency's direction and activities for the next three years. Its underlying strategy is straightforward: to concentrate on the EMCDDA's core business of monitoring the drugs phenomenon and to ensure that full value is secured from the investments made in this area. Its guiding principles are a commitment to scientific excellence, partnership, good governance and efficiency.

For more on the 2007–2009 work programme, see www.emcdda.europa.eu/?nnodeid=25311

### BZP under formal scrutiny

*Cited from Roumen Sedefov* Drugnet Europe *No. 58, April–June 2007*

Europe has responded to rising concern over the use of the stimulant drug BZP by formally requesting an investigation into the health and social risks of the substance. …The risk-assessment exercise, which will result in a report by mid-June, will be undertaken by the EMCDDA's Scientific Committee, with participation of additional experts from the European Commission, Europol and the European Medicines Agency (EMEA). The exercise is part of a three-step procedure: information exchange, risk assessment and decision-making.

### New project to improve TDI data coverage

*Cited from Linda Montanari* Drugnet Europe *No. 58, April–June 2007*

Assessing and improving data coverage in the area of treatment demand is the aim of a new EMCDDA project launched in April 2007. Oriented by proposals from an expert group meeting in February, the project will be carried out in eight volunteer countries and is scheduled for completion by summer. The results will be presented in September at the EMCDDA's annual treatment demand expert meeting in Lisbon.

### Commission launches report on harm reduction in the EU

*Cited from Dagmar Hedrich* Drugnet Europe *No. 58, April–June 2007*

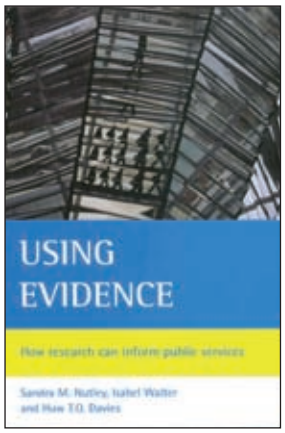
The European Commission launched a report in April on the prevention and reduction of health-related harm associated with drug dependence in the EU [COM(2007) 199 final]. The report assesses to what extent Member States have implemented a 2003 Council recommendation which aimed to reduce drug-related deaths and health damage by encouraging countries to develop specific services and facilities.

In its conclusions, the Commission report states that all Member States have now installed policies and actions reflecting proposals set out in the 2003 recommendation, but the level of implementation varies within and between countries. And while high-quality data exist on the availability of harm-reduction services, data on their accessibility and utilisation, especially by high-risk groups, should be improved.

*Drugnet Europe* is the quarterly newsletter of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). An electronic version of *Drugnet Europe* is available on the EMCDDA website at www.emcdda.europa.eu

If you would like to receive a hard copy of the current or future issues of *Drugnet Europe,* please contact: Alcohol and Drug Research Unit, Health Research Board, Knockmaun House, 42–47 Lower Mount Street, Dublin 2; Tel: 01 2345 127; Email: adru@hrb.ie

# Recent publications




## Books

### Using evidence: how research can inform public services

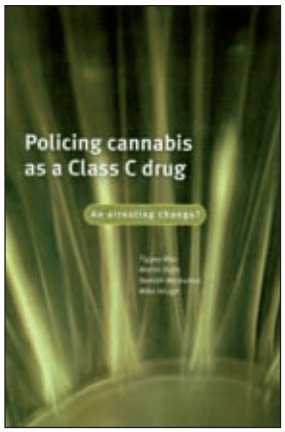
Nutley M, Walter I and Davies H

The Policy Press 2007, 363 pp.

ISBN 978 1 86134 664 3

This book examines the ways in which research can influence debate, policy choices and practice arrangements, how such influence is mediated, blocked or amplified, and how its impact might be enhanced. The authors discuss what we know about the influence of research on national and local policy actors and front-line practitioners, believing that the ways in which research is combined with other forms of evidence and knowledge could have important impacts on the nature, distribution, effectiveness, efficiency and quality of public services. They take particular care to locate their interest in 'research use' as being more wide-ranging than the often limited scope inferred by the expression 'evidence-based policy and practice'. The book draws on studies of 'research use' in four key public service areas: health care, social care, education and criminal justice.

The first chapter introduces the issues in the historical context of the evidence-based policy and practice agenda. The next three chapters attempt to answer the questions: What is research use? What shapes its uptake? How has research use been modelled? Further chapters lead to a synthesis of what this understanding can mean for increasing or influencing research use in the field. These chapters discuss the evidence of the effectiveness of different mechanisms for promoting the use of research, what we can learn from the literature on learning and knowledge management, and what strategies for improving research use are available and likely to be effective. The final two chapters address the challenges facing those who seek to assess the wider impacts of social research, and draw some conclusions from the linking arguments presented throughout the book.




### Multi-component programmes: an approach to prevent and reduce alcohol-related harm

Thom B and Bayley M

Joseph Rowntree Foundation 2007, 82 pp.

ISBN 978 1 85935 549 7
(PDF available at www.jrf.org.uk)

A key part of UK national strategy on reducing alcohol-related harm is a focus on local responsibility for policy implementation and an expectation that stakeholders – local authorities, professional groups, the alcohol trade and 'communities' – will work together in addressing the problems.

This report reviews international experience of community-based prevention programmes to address alcohol-related harms at local level. It describes a 'multi-component' model, with evidence from programmes in the USA, Australia, New Zealand and Scandinavia. The approach typically requires a programme of multiple, co-ordinated initiatives rather than 'stand-alone' projects, and an emphasis on encouraging change in local policies, structures, systems and drinking cultures. The involvement of local communities is central to most programmes. The report reveals problems in implementing and sustaining this approach as well as the advantages it offers. Discussions with a small group of professionals showed widespread use of 'partnership' approaches and suggested that the use of a more explicit multi-component model would be helpful to map alcohol-related problems and design local strategies.

The introductory chapter gives the background and rationale for multi-component programmes and sets out the authors' aims and the methods used. Chapter 2 provides an overview of the identified programmes, their aims, structures and components. The third chapter discusses evaluation and considers whether these programmes 'work' or are more likely to succeed than stand-alone projects. Chapter 4 introduces two main theoretical frameworks that inform the development and implementation of many multi-component programmes. Chapter 5 considers some key issues influencing the development of multi-component approaches, and a brief Endnote sums up the potential for such approaches to make a contribution in the UK context, taking account of the influence of national policies on local action. Details of the multi-component programmes identified, a table summarising reported programme evaluations and a list of publications consulted are given in three appendices.

### Policing cannabis as a Class C drug: an arresting change?

May T, Duffy M, Warburton H and Hough M

Joseph Rowntree Foundation 2007, 55 pp.

ISBN 978 1 85935 543 5
(PDF available at www.jrf.org.uk)

In the UK in January 2004, cannabis was reclassified from a Class B to a Class C drug. This report, by the Institute for Criminal Policy Research at King's College London, describes the impact of reclassification on the policing of cannabis possession. To date, little research has been carried out in this area and there is a lack of knowledge about how reclassification

## Recent publications *(continued)*

has affected policing practice. The study reported here largely replicates a study of cannabis policing that was carried out before reclassification (May *et al.* 2002). For this report, researchers returned to the same sites, where they observed patrol officers at work, interviewed officers and young people, analysed custody records and street warning statistics, and mounted an internet survey on people's knowledge about, and attitudes towards, the cannabis laws.

The study describes how the legislative changes and associated guidelines have been put into practice and provides a snapshot view of the impact of these changes. It describes the new procedures and documents current practice in relation to arrests for 'aggravated possession' and warnings issued on the street (particularly for repeat offenders). The report also assesses the impact on police resources, explores police views about the changes and examines young people's knowledge and attitudes about the changes.

The authors conclude that if cannabis policing is to be seen as equitable and fair and the criminal justice system as open and transparent, the policing of cannabis needs to be non-discriminatory, adequately monitored and critically evaluated at regular intervals.

## Journal articles

**The following abstracts are cited from recently published articles relating to the drugs situation in Ireland.**

### Nalbuphine (Nubain): Non-prescribed use, injecting, and risk behaviors for bloodborne viruses

McElrath K and Connolly D

*Contemporary Drug Problems* 2006; 33(2): 321–340

Nalbuphine hydrochloride is a synthetic opiate with agonist-antagonist properties that has been prescribed for pain relief in several countries in North and Central America, Europe and elsewhere. Marketed for several years under the trade name Nubain, the drug was believed to have low potential for dependence. Research into nalbuphine misuse is limited but studies have documented misuse among some bodybuilders, weightlifters, and users of anabolic steroids. This study examines patterns of nalbuphine misuse and injecting behaviours that pose risk for blood-borne viruses among 10 respondents residing largely in one community in Ireland. Contrary to other research findings, most individuals had no history of weightlifting and no experience with the use of anabolic steroids. Most of the respondents had injected nalbuphine several times per day, and reported frequent injection of stimulants. Respondents reported that needles and syringes were scarce. At least some of the nalbuphine in the region has been found to be 'counterfeit'. Implications of the findings are discussed.

### Challenging times: prevalence of psychiatric disorders and suicidal behaviours in Irish adolescents

Lynch F, Mills C, Daly I and Fitzpatrick C

*Journal of Adolescence* 2006; 29(4):555–73

Against a background of a lack of systematic epidemiological research in the area in Ireland, this study set out to determine prevalence rates of psychiatric disorders, suicidal ideation and intent, and parasuicide in a population of Irish adolescents aged 12–15 years in a defined geographical area. All 12–15-year olds attending eight secondary schools were eligible for inclusion. A two-stage procedure involving a screening and an interview phase was used. Those scoring in the clinical range on the screening measures were interviewed, along with a comparison group matched for gender, school and school year. Of the 723 adolescents screened, 19.4% were identified as being 'at risk'. This 'at risk' group was interviewed along with a comparison sample. Of the total study population, 15.6% met the criteria for a current psychiatric disorder, including 4.5% with an affective disorder, 3.7% with an anxiety disorder and 3.7% with ADHD. Significant past suicidal ideation was experienced by 1.9%, and 1.5% had a history of parasuicide. Binge drinking was associated with both affective and behaviour disorders. The authors conclude that rates of psychiatric disorders and suicidal behaviours in young Irish adolescents are similar to those in other Western cultures and that mental health promotion should be given priority in schools.

### Factors affecting the outcome of methadone maintenance treatment in opiate dependence

Kamal F, Flavin S, Campbell F, Fagan J, Behan C and Smyth R

*Irish Medical Journal* 2007; 100(3):393–7

This study aimed to measure the rates of ongoing heroin abuse among patients on methadone maintenance treatment (MMT) and to identify patient and treatment characteristics associated with poorer outcome. The study was carried out at an outpatient drug treatment clinic and included all patients who were on MMT during a three-month period in 2004. Treatment response was measured by analysis of opiate-positive urine samples. Of the 440 patients, 63% were male and their mean age was 32 years (range 17 to 52 years); 163 patients (37%) had a co-existing psychiatric illness. The average methadone dose was 74mg. On average, 71%

## Recent publications *(continued)*

of urine samples were opiate-negative. Shorter time in treatment (less than 24 months), lower dose of methadone, cocaine abuse and intermittent benzodiazepine abuse were each found to be significantly associated with lower rates of opiate abstinence. Outcomes were not associated with gender, age or receipt of counselling. Dual-diagnosed patients tended to have higher rates of abstinence (p=0.08). MMT clients who abuse cocaine and benzodiazepines are at increased risk of continuing opiate abuse. Higher doses of methadone might be necessary to prevent illicit opiate abuse.

### Epidemiology of hepatitis C infection, ERHA/ HSE Eastern Region

O'Meara M, Barry J and Mullen L

*Irish Medical Journal* 2007; 100(2):365–6

Hepatitis C became statutorily notifiable in Ireland on 1 January 2004. Prior to 2004, only hepatitis A and hepatitis B were notifiable as distinct types of hepatitis. A third category, notifiable under the Infectious Diseases Regulations 1981, was 'viral hepatitis unspecified'. The majority of cases notified under this heading were thought to be due to infection with hepatitis C virus (HCV). Between 1 January 2004 and 31 December 2005, the Department of Public Health HSE Eastern Region, received notification of 2,014 cases of HCV infection (2004, 941 cases; 2005 1,073 cases). This report outlines basic demographic details on cases notified, and comments on missing data. Peak age band at notification for males and females was in the 25-29 year old age group where 538 (26.7%) were notified. Thirty cases notified (1.5%) were under 15 years of age. Drug misuse has been confirmed as a risk factor for 1,247 (61.9%) of cases notified, and may be a risk factor in a large percentage of the reminder, where risk factor data are unknown. Problems with completeness of notification have been identified. Enhanced surveillance of all hepatitis C infections is a prerequisite for future service planning.

### Alcohol dependence and mood state in a population receiving methadone maintenance treatment

MacManus E and Fitzpatrick C

*Irish Journal of Psychological Medicine* 2007; 24(1): 19–22

The aim of this study was to assess the prevalence of alcohol dependence and anxiety and depressive disorder symptomatology among heroin users in drug treatment. Fifty-five clients on methadone maintenance treatment programmes in Dublin were interviewed. Prevalence rates were found to be 56% [n=31] for alcohol dependence, 56% [n=31] for anxiety disorder symptomatology, and 42% [n=23] for depressive order symptomatology. This finding of comorbid alcohol dependence and psychopathology among methadone maintenance treatment clients suggests that both clients' health and methadone maintenance treatment participation and completion rates may be compromised. The author concludes that alcohol dependency and psychopathology among methadone maintenance treatment clients should be considered when providing effectively targeted services to the drug-using population.

### Management of hepatitis C among drug users attending general practice in Ireland: baseline data from the Dublin area hepatitis C in general practice initiative

Cullen W, Stanley J, Langton D, Kelly Y and Bury G

*European Journal of General Practice* 2007; 13(1):5–12

In Ireland, general practice is increasingly providing long-term care for injecting drug users, 62%–81% of whom are infected with hepatitis C (HCV). Clinical guidelines for the management of HCV among drug users have recently been developed in Ireland, and this study aimed to describe HCV care among drug users attending general practice in the greater Dublin area, prior to the implementation of the clinical practice guidelines. The clinical records of 196 patients attending 25 general practices in the Eastern Regional Health Authority area for methadone maintenance treatment were examined on site and anonymized data collected on HCV care processes. Patients had been attending general practice for methadone maintenance treatment for a mean of 30.7 months; 72% were male and 51% had tested positive for metabolites of drugs of abuse other than methadone in the previous three months. There was evidence that 77%, 69% and 60% had been screened for HCV, human immunodeficiency virus (HIV) and hepatitis B (HBV), respectively. Among those who had been tested, the prevalence of HCV, HIV and HBV infection was 69%, 10% and 11%, respectively. Of those known to be HCV positive, 36 (35%) had been tested for HCV-RNA (29 testing positive), 31 (30%) had been referred to a hepatology clinic, 24 (23%) had attended a clinic, 13 (13%) had a liver biopsy performed and three (3%) had started treatment for HCV. While the majority of patients have been screened for blood-borne viruses, a minority of those infected with HCV have had subsequent investigations or treatment. New interventions to facilitate optimum care in this regard need to be considered.

*(Compiled by Joan Moore and Louise Farragher)*

# Upcoming events

*(Compiled by Louise Farragher – lfarragher@hrb.ie)*

## June

22–24 June 2007

### ENCOD – European Coalition for Just and Effective Drug Policies General Assembly

**Venue:** Lange Lozanastraat 14, 2018 Antwerp, Belgium

**Organised by / Contact:** Tel: +32 (0) 3 293 0886

**Email:** info@encod.org
www.encod.org

**Information:** ENCOD members are invited to the general assembly to discuss the following topics:

- The dialogue with the European Union
- The ENCOD website
- The Vienna 2008 campaign
- The 2007–2008 work plan
- The approval of the Annual Report and the election of a new Steering Committee

## July

1–3 July 2007

### First world conference on medication assisted treatment of opiate addiction

**Venue:** Cankarjev, Ljubljana, Slovenia

**Organised by / Contact:** European Opiate Addiction Treatment Association (EUROPAD), American Association for the Treatment of Opioid Dependance (AATOD) and South Eastern European Adriatic Addiction Treatment Network (SEEAnet).
www.seea.net

**Information:** This three-day interdisciplinary conference will discuss practice, drug policy research and evaluation in the field of medical assisted treatment of opiate addiction (substitution treatment).

5 July 2007

### Economic and Social Research Council seminar. Life after punishment: drug use and desistance

**Venue:** The Council Room, Kings College London, Strand Campus, 151–171 Strand, London WC2R 2LS

**Organised by / Contact:** tim.mcsweeney@kcl.ac.uk

**Information:** This is one in a series of seminars funded by the Economic and Social Research Council on the topic 'life after punishment'. The seminars have been built around the concepts emerging from criminological 'desistance' theories. The 5 July seminar, chaired by Mike Hough, will focus on drug use and desistance. The aim of the seminar is to explore whether there is any overlap or contradiction between perspectives on desistance from offending and narratives on recovery from dependent patterns of drug use. The seminar will examine recent research to consider whether these paradigms contradict or complement each other.

## September

20 September 2007

### 28th annual EAP Conference: Drugs and alcohol – complying with the Safety, Health and Welfare at Work Act 2005

**Venue:** Carlton Hotel, Dublin Airport

**Organised by / Contact:** EAP Institute 143 Barrack Street, Waterford, Ireland Tel: +353 (51) 855733

**Email:** anita@eapinstitute.com
www.eapinstitute.com

**Information:** The Safety, Health and Welfare at Work Act 2005 obliges employers to remove from their place of work employees who are under the influence of intoxicants (defined as drugs and alcohol). A finding by the Labour Court in 2006 that alcoholism is a disability will oblige employers to provide treatment and rehabilitation to employees. This one-day conference will address the following issues:

- Managing drugs and alcohol at work
- Trade union approach
- Legal risk management
- Maintaining a drug-free work place
- Employee drug testing
- Manager training

## October

1–3 October 2007

### 10th International Symposium on Substance Abuse Treatment

**Venue:** Oslo, Norway

**Organised by / Contact:** Norwegian Institute for Alcohol and Drug Research (SIRUS)

For questions about the program, contact Edle Ravndal: Tel: +47 22 34 04 42

**E-mail:** er@sirus.no

## Upcoming events *(continued)*

For questions about registration, accommodation, payment, etc., contact: Nada Halabi
Tel: +47 22 34 04 00

**E-mail:** nh@sirus.no

**Information:** The 10th International Symposium on Substance Abuse Treatment aims to gather both researchers and practitioners within the field of substance abuse treatment in Europe. The theme for this year's conference will be reforms, ideology and best practice. This symposium is a collaboration between the European Working Group on Drug Oriented Research and the European Federation of Therapeutic Communities.

## November

8–9 November 2007

### 3rd conference on local, integrated & participative responses to the issue of drugs use

**Venue:** Venice, Italy

**Organised by / Contact:**
Thierry Charlois, project manager
Tel: +33 (0)1 40 64 49 00
info@democitydrug.org
www.democitydrug.org

**Information:** The results of three years of practice-sharing between European cities will be presented at this, our third conference. Elected officials, social and health workers, peers, volunteers, police officers, judges and community members will work together on the evolution of drug-related problems. At round-table sessions, translated into Italian, English and French, delegates will discuss the limits faced by partnerships as well as the innovative practices overcoming these obstacles.

14 November 2007

### Writing for Publication in Addiction Journals

**Venue:** Park Inn Hotel, York, UK

**Organised by / Contact:** Society for the Study of Addiction and the International Society of Addiction Journal Editors. For more details and application forms, see the SSA website: www.addiction-ssa.org

**Information:** Want to improve your chances of getting your research published in peer-reviewed journals? You are invited to a one-day workshop on writing for publication run jointly by the Society for the Study of Addiction and the International Society of Addiction Journal Editors. The course is suitable for doctoral students, post-doctoral research trainees, and junior investigators. Tutors are addiction journal editors with many years' experience. Participants will get an inside look at how editors work and how they make decisions about what material to publish. Before coming to the workshop, participants are recommended to read Publishing Addiction Science: A Guide for the Perplexed. Free downloads from www.parint.org and www.isaje.net

15–16 November 2007

### SSA Annual Symposium 2007: Is theory necessary? Theory, policy and treatment in addictions: How are they related?

**Venue:** Park Inn Hotel, York, UK

**Organised by / Contact:** Society for the Study of Addiction
www.addiction-ssa.org

**Information:** The theme of this year's symposium includes:

- Theory, practice and treatment in addictions: How are they related?
- What are the new developments in addictions treatment?
- Society lecture: A vision of the future of addictions treatment

**The Alcohol and Drug Unit (ADRU) of the Health Research Board is a multi-disciplinary team of researchers and information specialists who provide objective, reliable and comparable information on the drug situation, its consequences and responses in Ireland. The ADRU maintains two national drug-related surveillance systems and is the national focal point for the European Monitoring Centre for Drugs and Drug Addiction. The unit also manages the National Documentation Centre on Drug Use. The ADRU disseminates research findings, information and news through its quarterly newsletter, *Drugnet Ireland,* and other publications. Through its activities, the ADRU aims to inform policy and practice in relation to drug use.**

***Drugnet Ireland* mailing list**

If you wish to have your name included on the mailing list for future issues of *Drugnet Ireland,* please send your contact details to:

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Please indicate whether you would also like to be included on the mailing list for *Drugnet Europe.*